

Kenya National Commission on Human Rights

Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?



A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya



April 2012



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Foreword

Sexual and reproductive health is a fundamental human right as well as human development issue that states must strive to fulfill. This right is guaranteed in various international and regional human rights instruments as well as national laws and policies.

Kenya is a state party to various international and regional human rights instruments that guarantee the right to sexual and reproductive health. Furthermore, the Constitution of Kenya 2010, for the first time guarantees the right to health care including reproductive health. It further provides that no one shall be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants. (Article 43(1) (a) (2) and (3)). The government has also developed a number of policies and established various institutions that seek to promote and protect the sexual and reproductive health rights of Kenyans. As such, Kenya is obligated to work towards the fulfillment of this right in line with these international and domestic standards.

In spite of these elaborate measures, violations of the right to sexual and reproductive health continue to be experienced throughout the country. In 2009, the Federation of Women Lawyers- Kenya and the Centre for Reproductive Rights- USA filed a complaint with the Kenya National Commission on Human Rights regarding systematic violation of women's reproductive health rights in Kenyan health facilities. This prompted the Commission to launch an expanded Inquiry into the extent of violation of reproductive health rights in Kenya. This was in line with its mandate- to conduct investigations into any complaint on the violation of human rights in the country. The aim of the Inquiry was to establish the extent and nature of violation of sexual and reproductive health rights and recommend appropriate redress measures.

The Inquiry did confirm that indeed the sexual and reproductive health rights of Kenyans are being violated. This is in terms of unavailability of essential sexual and reproductive health services, difficulties in accessing these services owing to distance or cost, the high charges levied on the services- making them beyond the reach of majority poor, the poor quality of the available services and the lack of sensitivity to the cultural norms and beliefs of the people in service delivery. The state has also not complied with its obligation

to dedicate the maximum of its available resources to progressively realise the right to sexual and reproductive health. Sexual minorities (gay, lesbian, bisexual, transgender, intersex persons and sex workers) and marginalised and vulnerable groups (people with disabilities, people living with HIV and AIDS, Adolescents and youth, internally displaced persons and refugees) were particularly noted as most vulnerable to these violations.

The Commission thus makes a number of fundamental recommendations that the state and other stakeholders should consider in working towards the realisation of sexual and reproductive health rights of all Kenyans. It is the sincere hope of the Commission that the stakeholders in the sector will find the findings of this Inquiry important and useful in informing their programming, policy dialogue and other measures aimed at enhancing the realisation of sexual and reproductive health rights in Kenya.

Dr. S. K. Tororei

Ag. Chairperson

Kenya National Commission on Human Rights

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To all we say, asante sana.

Winfred O Lichuma (Commissioner and Chair to the Inquiry Panel)

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Ante-Natal Care
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community Based Organisation
CDF	Constituency Development Fund
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CPR	Contraceptive Prevalence Rate
CRR	Centre for Reproductive Rights
FBO	Faith-Based Organisation
FGM/C	Female Genital Mutilation/Cutting
FIDA	Federation of Women Lawyers-Kenya
FP	Family planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GOK	Government of Kenya
GIZ	German International Cooperation
HIV	Human Immunodeficiency Virus
IARC	International Agency for Research on Cancer
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
ICESCR	International Covenant on Economic, Social and Cultural Rights
IUD	Intrauterine Device
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KNBS	Kenya National Bureau of Standards
KNCHR	Kenya National Commission on Human Rights
KNH	Kenyatta National Hospital
KSH	Kenya Shilling
LGBTIs	Lesbians, Gays, Bisexuals, Transgendered and Intersex
MARPS	Most at Risk Populations
MDGs	Millennium Development Goals
MNH	Maternal and Newborn Health

MOH	Ministry of Health
MOMS	Ministry of Medical Services
MPHS	Public Health and Sanitation
NGO	Non-Governmental organisation
NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan 1999-2004
NRHS	National Reproductive Health Strategy
OBA	Output Based Approach
PWD	Persons with Disabilities
RH	Reproductive Health
RVF	Recto-Vaginal Fistula
SDGEA	Solemn Declaration on Gender Equality in Africa
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually transmitted infections
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
UN	United Nations Organisation
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USA	United States of America
VCT	Voluntary Counselling and Testing for sexually transmitted infections
VVF	Vesico-Vaginal Fistula
WHO	World Health Organisation

Executive Summary

Introduction

The Kenya National Commission on Human Rights in 2011 launched a public inquiry into violations of sexual and reproductive health rights (SRHR) in Kenya. This was following a complaint filed in 2009 by the Federation of Women Lawyers – Kenya and the Centre for Reproductive Rights – USA alleging systematic violation of women's reproductive health rights in Kenyan health facilities. The Inquiry aimed to establish the extent and nature of violation of sexual and reproductive health rights and recommend appropriate redress measures.

The Inquiry brought together stakeholders in the sexual and reproductive health rights subsector to discuss the various human rights violations with regards to sexual and reproductive health. These included members of the public who had experienced or witnessed violation of SRHRs, sexual reproductive health experts, government officials, representatives of civil society organisations working in the health sector, and health care providers. Information was collected using desk research, public hearings, and field interviews. The Inquiry was guided by principles espoused in the human rights based approach framework of UNFPA- creating an enabling policy framework, widening access to vulnerable and disadvantaged groups, building awareness, and encouraging involvement.

Contextualising Sexual and Reproductive Health Rights in Kenya

According to the United Nations International Conference on Population and Development-Cairo (ICPD) of 1994, sexual and reproductive health rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and

violence as expressed in human rights documents.¹

These rights are guaranteed in various treaty documents and other instruments which clearly delineate government obligations to protect the rights. At the international level, we have Covenant on Economic, Social and Cultural Rights (1966); Covenant on Civil and Political Rights (1966); Convention on the Elimination of all forms of Racial Discrimination (1966); Convention on the Elimination of all forms of Discrimination against Women (1979), Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984); Convention on the Rights of the Child (1989); and Convention on the Rights of Persons with Disabilities (2006). At the regional level, we have The African Charter on Human and Peoples' Rights (1981); African Charter on the Rights and Welfare of the Child (1990); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa or the "Maputo protocol (2003). Others include the Millennium Development Goals, Abuja Declaration (2001) on HIV and AIDS, Tuberculosis (TB) and other related Infectious diseases; Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009) among others.

At the national level, the Constitution of Kenya 2010 guarantees the rights of an individual to the highest attainable standard of health, including reproductive health. It underscores the importance of prioritising the needs of vulnerable and marginalised groups in provision of health care. In addition to the Constitution, Kenya has a number of Acts of Parliament that seek to promote and protect sexual and reproductive health rights, which include the Sexual Offences Act 2003, the Children's Act 2001, Prohibition of Female Genital Mutilation Act 2011 among others. There are also a number of policies and strategies on sexual and reproductive health including the National Reproductive Health Policy, 2007, the National Reproductive Health Strategy 2009-2015; the Adolescent Reproductive Health and Development Policy, 2003; the National Condom Policy and Strategy (2009-2014; the Contraceptive Policy and Strategy (2002-2006); the Contraceptive Commodities Procurement Plan (2003-2006); the Contraceptive Commodities Security Strategy (2007-2012); the School Health Policy; the Female Genital Mutilation/

¹ See WHO definition of Reproductive rights and is found on Wikipedia available at http://en.wikipedia.org/wiki/Reproductive_rights#cite_note-autogenerated1-1 (accessed on 19 March 2012)

Cutting Policy; the HIV and AIDS Strategic Plan (2009/10-2012/13); the National Reproductive Health and HIV and AIDS integration Strategy-August 2009; the National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans, October 2007; the National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya, August 2010.

These international, regional and national instruments place an obligation on the state to respect, protect, and fulfil the sexual and reproductive health rights of all Kenyans by ensuring that essential services are available, accessible, acceptable and of good quality. The State is obligated to fulfil SRHR 'progressively', depending on the available resources. This requires it to demonstrate 'measurable progress towards the full realisation of the SRHR and to restrain from adopting 'regressive measures'. The State is further obligated to fulfil those rights that require immediate realisation such as freedom from discrimination and freedom to control one's health and body.

Nature and Extent of Violation of Sexual and Reproductive Health Rights in Kenya

1. Family Planning

Family planning is a key intervention for improving the health and wellbeing of women and their families. It provides couples and individuals the means to prevent unwanted pregnancies and time the formation of their families. It enables women to exercise choice and control over their fertility; reduces maternal and perinatal morbidity and mortality; reduces the risk of STIs, including HIV transmission; advances gender equality, and increases women's opportunities for education, employment and full participation in society.

Despite the key role that family planning plays in sexual and reproductive health, the unmet need still remains high. The inquiry determined that most Kenyans who desire to plan their families still do not have access to family planning services. This is owing to a number of barriers including:

- Unavailability of family planning commodities in the health facilities demonstrated by frequent stock-outs;
- Structural barriers prohibiting village community health workers

from carrying emergency contraceptives or directly offering injectables and unavailability of long acting methods in lower level facilities;

- Cultural norms and practices that place decision making authority regarding number of children on the man and myths that equate the use of family planning to immorality;
- Lack of accurate information on family planning resulting in propaganda and misinformation around family planning;
- Perceived high cost of family planning, making it out of reach of majority poor.

These barriers exist against the backdrop international, regional and domestic human rights instruments that oblige the government of Kenya to give effect to this component of the right to sexual and reproductive health.

In order to meet the family planning needs of Kenyans, the Inquiry recommends the following:

- Expansion of access to and demand for a broader mix of family planning methods;
- Promotion of gender equality as a prerequisite for increasing uptake of family planning;
- Investment in community structures- such as community health workers - for effective delivery of FP services;
- Elimination of fees associated with access to family planning services in both public and private facilities;
- Addressing of the socio-cultural barriers to family planning with a view to ensure that all persons can access the services;
- Involvement of men in family planning initiatives and programmes;
- Availability of accurate information regarding family planning to enable people make informed choices;
- Integration of family planning into the broader development agenda.

2. Maternal Health

The World Health Organisation defines maternal health to refer to the health of women during pregnancy, childbirth and the postpartum period. As such, the right to maternal health should encompass access

to antenatal care services; delivery services, including caesarean section where necessary; essential newborn care services and post-partum care within two days of delivery. Provision of these requires availability of trained service providers (midwives, nurses, doctors and clinical officers) at all times and the capacity of facilities to respond to emergency cases, adequate physical facilities, adequate equipment and supplies including essential medicines and vaccines.

Findings of the Inquiry point to a number of barriers that inhibit the realisation of maternal health rights in Kenya:

- Unavailability of maternal health services - including antenatal care, delivery care, postpartum care and abortion care – at all levels of health care;
- The long distance covered to access the maternal health services- especially in the far flung areas such as Northern and North Eastern region;
- Poor quality of maternal health services occasioned by lack of supplies and equipment, understaffing and inadequate training and supervision, negligence and unethical practices, and weak referral systems;
- High cost of maternal health care, making the use of skilled health attendants out of reach for many Kenyans;
- Failure to tailor maternal health care services to respond to the cultural norms and practices of particular communities such as those who do not allow a pregnant woman to be attended to by a male health care provider;
- Failure to integrate traditional birth attendants into the broader health care system with a view to regulate their operations in order to make them safe for women who seek their services.

These barriers persist in spite of the existence of a legal and policy framework that aims to improve maternal health in Kenya.

The Inquiry therefore makes the following recommendations aimed at improving maternal health in Kenya.

- Implementation of the Human Rights Council resolution on preventable maternal mortality by adopting a human rights based approach to all interventions aimed at mitigating maternal mortality and morbidity;

- Development of a strategy to address all the causes of delays that eventually lead to maternal deaths;
- Adequately equipping lower-level facilities to handle all cases relating to maternal health that they were designed to handle and reduce the number of cases they refer either due to shortage of skilled providers or essential equipment;
- Recruitment of adequate staff;
- Adoption of a health financing policy and strategy that will make maternal health services affordable to all people irrespective of their socio-economic status;
- Strengthening the referral system to ensure effective linkages between lower levels of care and higher levels of care, especially;
- Implementation of health practitioners codes of ethics and standards with a view to eradicate malpractices and negligence;
- Undertaking of an elaborate health education programme targeted at both community level and health care providers with a view to increase the uptake of maternal health care services by the communities and improve the quality of health care services provided by the health facilities;
- Development of standards and guidelines on lawful abortion as provided for in the Constitution of Kenya 2010.

3. Sexual Violence

During the Inquiry, witnesses reported incidences of sexual violence in the form of rape, defilement, female genital mutilation, early/forced marriages, among others across the country. Witnesses reported profound effects emanating from these acts of violence including unwanted pregnancies, infection with STI's including HIV and AIDS, numerous gynaecological complications, stigma, abandonment by their spouses and psychosocial trauma.

A number of factors were identified to perpetuate sexual violence including historical unequal power relations between men and women, socio-cultural factors, the culture of impunity which is rooted in the normalisation of violence against women, complex, burdensome and humiliating justice system, conflict and breakdown of law and order/ conflict.

A number of barriers were reported to inhibit access to remedies by victims of sexual violence including:

- Lack of one-stop facilities to obtain integrated services- facilities where victims can report complaints, get examined and treated, receive emergency contraceptives, obtain STI and HIV tests and gets engaged in long term prevention measures such as HIV management through ARVs;
- Lack of awareness among victims of the services that exist;
- Difficulties in obtaining documentation- especially the P3 Form- to prove that one was violated;
- The high cost of especially post-rape services;
- Burdensome and often humiliating justice system.

Noteworthy, incidences of sexual violence continue to be reported across the country despite the legal and policy framework in place. In order to work towards the protection of the sexual and reproductive health rights of all Kenyans, the Inquiry recommends the following:

- Full implementation of legislation relating to sexual violence including the Sexual Offences Act, Prohibition of Female Genital Mutilation Act among others;
- Removal of all barriers to access to justice for victims/survivors of sexual violence-including relaxing the requirements for prosecuting offences related to sexual violence ;
- Putting in place a one-stop facility that can offer integrated services- legal, health, psycho-social- to the victims/survivors;
- Urgent ratification of the optional protocol to CEDAW that will allow citizens to file individual complaints to the Monitoring Committee once they exhaust domestic remedies.

4. Sexual and Reproductive Health Rights of Sexual Minorities

The Inquiry determined that sexual minorities such as lesbian, gay, bisexual, transgender and intersex persons (LGBTIs) suffer numerous human rights violations on the basis of their sexual behaviour and orientation. These include discrimination and stigma, exclusion from decision making processes- meaning that their SRH needs are never captured, limited access to SRH services, violence and harassment,

lack of proper knowledge on how to protect themselves from STIs and HIV, unaffordable SRH services, and lack of recognition by the society of their existence. The transgender are particularly not able to access gender reassignment therapy owing to the unavailability of such services in Kenya coupled with discrimination and stigma.

It particularly becomes difficult to safeguard the sexual and reproductive rights of sexual minority groups owing to their criminalisation. The Kenyan Penal Code for instance criminalises homosexuality and living off the proceeds of prostitution (sex work). Although some see the Kenyan Constitution 2010 as presenting an opportunity to safeguard the rights of sexual minorities, the hostile societal attitude towards these groups will have to be dealt with if meaningful gains with respect to their SRHR are to be realised. The Inquiry made the following recommendations towards this end:

- The government should decriminalise same sex relationships and sex work with a view to ensure that they enjoy the human rights enshrined in the Constitution 2010 under the Bill of Rights;
- Health care providers must consider sexual minorities as a vulnerable groups with a view to put in place programmes that respond to their unique SRH needs and challenges including prevention of STIs and HIV infections;
- There is need for community sensitisation with a view to cultivate tolerance and acceptance of sexual minorities in society;
- The government and other stakeholders must appreciate the SRH needs of the transgender people and formulate policies and programmes to respond to these needs. For instance SRH services relating to gender reassignment must be available at affordable costs and they must be facilitated to change the identities in their documents.

5. Sexual and Reproductive Health Rights of Vulnerable and Marginalised Groups

Vulnerable and marginalised groups such as adolescents, youth, people with disabilities, people living with HIV and AIDS, internally displaced persons and refugees are often excluded from service provision, including SRH.

With regards to adolescents and youth, the Inquiry heard that they suffer unwanted pregnancies, complications arising from unsafe abortions and child birth. They lack easy access to quality and friendly SRH including STI services, safe abortion services, antenatal care and skilled attendance during delivery, which result in higher rates of maternal and perinatal mortality. They are also subjected to harmful cultural practices including female genital mutilation (FGM), early forced marriage, and sexual violence and abuse including coerced sex, incest, defilement and rape, which increase their risk to STIs including HIV. Generally adolescents and youth lack relevant accurate information on sex, sexuality and reproductive health.

On the other hand, persons with disabilities suffer discrimination and stigma, lack of informed consent regarding the medical procedures to be performed on them- with some going through medical operations like hysterectomy and caesarean sections without their consent, difficulties in accessing health facilities due to unfriendly physical infrastructure, high cost of SRH services given that most are poor, sexual harassment and mistreatment by health care providers, difficulties in accessing information owing to the unfriendly formats in which the information is presented such as lack of braille format for the blind and sign language for the deaf.

People living with HIV and AIDS on their part suffer violence, sexual harassment, forced sterilisation without their consent owing to the belief that they are not supposed to have children, misinformation and coercion to adopt family planning methods preferred by the health care providers, stigma and discrimination culminating in ostracisation and abandonment, abuse and mistreatment by health personnel especially during antenatal care and delivery, denial of right to have sex and found a family.

IDPs and refugees also suffer sexual violence while in camps coupled with limited access to SRH services due to their unavailability.

To address the SRHR concerns of vulnerable and marginalised groups in line with international human rights frameworks and domestic laws and policies, the Inquiry makes a number of recommendations for consideration:

Adolescents

- The Government must work towards ensuring that youth-friendly, non-discriminatory sexual and reproductive health services—including family planning services—are made widely available and accessible to all adolescents and youth in Kenya. The Ministries in charge of Health need to ensure that each facility has trained medical personnel in delivery of youth friendly services;
- Government must implement laws and policies that seek to protect the youth and adolescents from sexual violence.

Persons with Disabilities

- The government and other stakeholders should seek to enhance access by PWDs to RH services by making facilities friendly through improved physical infrastructure, use communication formats that are accessible by the deaf, blind, and persons with other forms of disabilities, and ensure the health equipment such as beds are easily accessible by those with physical disabilities;
- The government must take measures to protect PWD from abusive and coercive practices, such as coercive sterilisation, while seeking sexual and reproductive health services. Clear measures must be put in place to ensure that the right to informed consent for PWD is fully protected;
- The National Council for Persons with Disabilities must work with the Government to ensure full implementation of the Persons with Disabilities Act and specifically to promote the right to information on SRH and the right to health as guaranteed in the Convention on the Rights of persons with Disabilities and Section 20 of the Act.

People living with HIV and AIDS

- The government must resource and work towards addressing the gendered aspects surrounding the spread of HIV/ AIDs. This implies supporting gender equality and women's empowerment so as to reduce the skewed profiling of women and girls as vectors of HIV infection;

- Health care providers should be continuously sensitised on the importance to respect the dignity and rights of people living with HIV and AIDS and especially the vulnerabilities of women;
- The offending sections of the sexual offences Act and the HIV Prevention and Control Act that criminalise HIV transmission should be immediately repealed to comply with the Constitution 2010 that prohibits any form of discrimination based on several grounds including health status;
- The government and other stakeholders must aim to accelerate universal access to prevention, treatment, care as envisaged in the Abuja call of Accelerated Action Towards Universal Access to HIV and AIDS, TB and Malaria Services in Africa 2006.

IDPs and Refugees

- All refugees and IDPs camps must be linked to well equipped and functional health care facilities with a view to ensure that the SRH services are accessible and available to them.

6. Financing of Sexual and Reproductive Health Care Services

Adequate financing of SRH services is essential for the realisation of sexual and reproductive health rights in Kenya. However, the Inquiry heard that funding challenges had resulted in a weak health system thus resulting in inaccessible, unaffordable and poor quality SRH services. While spending in health care has increased over the years, this has mainly been as a result of increased contributions by donors. The Kenyan government is yet to meet its obligation of dedicating 15% of its budget to health as per the Abuja Declaration. The over reliance on donor funding in financing reproductive health poses the risk of unsustainability of the efforts and failure of the funds provided for the sector to meet the priorities. Further, the prioritisation and utilisation of available funding has not been equitable and effective. Lack of transparency has meant that stakeholders in the SRH sector have not had adequate opportunity to articulate their needs in the budgeting process, whilst bureaucratic delays mean that even when funds are available, they are frequently under spent.

It is notable that the sector has not had a Health Financing Strategy to guide its resource rationalisation and mobilisation approaches. Cost information is missing and expenditure review data and

recommendations are not applied. The draft Comprehensive National Health Policy Framework 2011-2030 does not address the issue of financial sustainability.

From the foregoing therefore, the Inquiry concludes that the government has not complied with its obligation to dedicate the maximum of its available resources to progressively realise the right to SRH. To remedy this, the Inquiry recommends that the government and stakeholders should:

- Remove financial barriers that result in the denial of or delays in receiving necessary SRH services;
- Implement the waiver systems in public health facilities;
- Increase the amount of resources allocated to the health sector;
- Ensure that resources allocated to the health sector are spent equitably and effectively;
- Ensure that the budgetary process is open and transparent and encourages public participation.

Chapter One

Introduction

1.1 Background to the Inquiry

This report presents the findings of the Public Inquiry into violations of sexual and reproductive health rights (SRHR) in Kenya. The Inquiry was undertaken in fulfilment of one of the Kenya National Commission on Human Rights' (KNCHR) primary mandates- to conduct investigations into any complaint on the violation of human rights in the country. The Inquiry was undertaken by the KNCHR following a complaint filed by two non-governmental organisations (NGOs) working on reproductive health issues in Kenya. The overall aim of the Inquiry was to establish the extent and nature of violation of sexual and reproductive health rights and recommend appropriate redress measures. The specific objectives of the Inquiry were to:

- Establish the legal and policy framework governing the implementation of sexual and reproductive health rights in Kenya and their effectiveness;
- Assess the extent to which the government and non-state actors are complying with their obligations relating to sexual and reproductive health rights in Kenya;
- Determine the extent of awareness and pursuit of sexual and reproductive health rights in Kenya;
- Identify and document cases of violation of sexual and reproductive health rights in Kenya.

1.2 The Complaint

In September 2009, the Federation of Women Lawyers -Kenya (FIDA-Kenya) and the Centre for Reproductive Rights- USA², (CRR) submitted a complaint to the KNCHR on allegations of violations of women's reproductive health rights in Kenyan health facilities, specifically Pumwani Maternity Hospital. The complaint was based on the findings of a study they had jointly conducted between November 2006

² FIDA- Kenya and CRR- USA are NGOs registered and working in Kenya on issues that include reproductive health rights.

and May 2007 among a sample of women, health care providers, hospital administrators, leaders of medical associations, and officials of licensing and regulatory bodies. The report titled 'Failure to Deliver'³ found that the Kenyan government was responsible for various severe reproductive health rights violations (see complaint letter in Annex 1). The study corroborated findings of a systematic review completed by these NGOs regarding government guidelines, standards and manuals on reproductive health services, and media coverage of reproductive health (RH) issues for the period 1997-2007.

KNCHR's preliminary assessment of the complaint pointed to the fact that violations of reproductive health rights were indeed being experienced in most government health facilities. These violations mainly stem from the poor quality of services provided in the health facilities, often resulting in low uptake or utilisation. There were indications of mistreatment and harassment of patients in health facilities, resulting in low utilisation of their services. It for instance emerged that women would avoid delivering in a health facility if they had personally experienced or were aware of a person who had experienced or suffered mistreatment, coercion, harassment or insult during a past delivery in a health facility. The complaint further pointed to failures by the government to provide quality health care services as demonstrated by health facilities that are underfunded and lack the necessary infrastructure and supplies essential for delivery of quality health care services. These, among other factors, necessitated the Commission to institute an expanded national public inquiry with a view to establish the nature and extent of violation of sexual reproductive health rights in Kenya and provide recommendations on how best to work towards the realisation of these rights.

1.3 The Kenya National Commission on Human Rights

The KNCHR was first established as a statutory body in 2003 pursuant to the KNCHR Act (No 9) of 2002. In August 2011 the KNCHR was reconstituted into a constitutional commission by article 59 (4) of the Constitution 2010 read together with the Kenya National Commission

3 FIDA- Kenya and CRR- USA (2007) Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities (online) available from <http://reproductiverights.org/en/document/failure-to-deliver-violations-of-women's-human-rights-in-kenyan-health-facilities> accessed on 25th October 2011)

on Human Rights Act, (No. 14) of 2011. The Constitution and the Act outline the mandate of the Commission, among them being to conduct investigations into any complaint on the violation of human rights in the country. This Inquiry was instituted under Section 16 (1) (a) of the 2002 Act which mandated the Commission 'to investigate, on its own initiative or upon a complaint made by any person or group of persons, the violation of any human rights'. The KNCHR Act 2011 confers the Commission with similar function under Section 8 (e) thereof.

In the last few years the Commission has undertaken several public inquiries⁴ covering human rights violations of a systemic nature and this was yet another one aimed at providing redress to alleged nationwide systemic violations of reproductive health rights.

1.4 Methodology

The Inquiry was undertaken through a consultative process, guided by the four objectives outlined above. Overall, the Inquiry process was guided by the principles espoused by the human rights based approach as stated in the UNFPA key strategies of applying human rights based approach to reproductive health. These are⁵:

- Creating an enabling policy environment that promotes reproductive health and rights, including building capacity to strengthen health systems, partnering with civil society and community-based organisations, and monitoring budgetary appropriations to ensure that reproductive health care is covered;
- Widening access to comprehensive reproductive health services, with an emphasis on disadvantaged groups;
- Building awareness of reproductive rights of women, men and adolescents so that they can claim them;
- Encouraging, involving and building the capacity of individuals and communities to participate in the design, implementation, monitoring and evaluation of reproductive health programmes and services that affect their lives.

⁴ A public inquiry into allegations of human rights violations in Magarini, Malindi, A Public Inquiry on National Insecurity and National Integration: Organised Criminal Gangs in Kenya available at <http://www.knchr.org> accessed on 3rd November 2011

⁵ Available at <http://www.unfpa.org/rights/approaches.htm> accessed on 20th December 2011.

The Inquiry employed a mix of approaches in gathering the necessary information. These approaches are discussed below:

a) Preparatory Stakeholders Forums

Two preparatory meetings were held between October 2010 and February 2011 involving representatives of key stakeholders in sexual reproductive health and human rights drawn from relevant government departments and civil society organisations. This aimed to review the objectives and scope of the Inquiry. The stakeholders acted as the broader reference group for the Inquiry, but more importantly, established the link between KNCHR and the wider stakeholders' constituencies in the society.

b) Desk Research

A comprehensive desk research involving the review of available literature and documentary evidence on sexual and reproductive health (rights) in Kenya was undertaken. Data from the desk research was analysed along broad themes derived from the main objectives of the Inquiry as follows:

- i. Legal and policy framework on sexual and reproductive health in Kenya.** This analysed the provisions of international law on right to sexual and reproductive health. The analysis entailed a review of the major international treaties, conventions, protocols and/or commitments relating to sexual and reproductive health to which Kenya is a signatory. It further analysed relevant national laws (including the relevant articles in the Constitution of Kenya) and policies relating to the fullest enjoyment of sexual and reproductive health rights in the country.
- ii. Access to information (awareness and education) on sexual and reproductive health in Kenya.** An analysis of existing documentary evidence on the levels of awareness and education on sexual and reproductive health among Kenyans was undertaken with a view to establish levels of access and exposure to SRH information. Special emphasis was put on the sources, quality, quantity and accessibility of reliable information on sexual and reproductive health.
- iii. Access to sexual and reproductive health care in Kenya.** A further analysis was undertaken to establish the extent

to which Kenyans are able to enjoy quality sexual and reproductive health care services. In particular, this focused on key indicators of sexual and reproductive health such as contraceptive use, maternal health, STIs and HIV and AIDS prevalence. The analysis also focused on the health care infrastructure development including the geographical distribution of health care facilities, supply of essential medical equipment and medicines, staffing levels and distribution of medical personnel, and financing of health care.

- iv. **Gaps in sexual and reproductive health care in Kenya.** A gaps analysis was undertaken to identify factors that undermine the fullest enjoyment of sexual and reproductive health rights in Kenya.

c) Field interviews

Field interviews were conducted between March and April 2011 with a view to corroborate the findings of the desk research and identify gaps to be addressed during the public hearings. Key informants drawn from six different regions across the country were interviewed. The six regions were purposively selected from a total of eight epidemiological zones developed by the Ministry of Public health and Sanitation. The six regions included; Coast, Nyanza/ Western, Central / Eastern, North Rift Valley, North Eastern, and Nairobi and its environs. This selection was aimed at capturing the diverse dimensions of sexual and reproductive health across the country with a view to ensure that the findings are representative of the SRHR situation of the entire country.

The field interviews targeted key stakeholders in the reproductive health subsector. These included the government, health services providers and consumers of health services- particularly SRH clients. The key informants were selected from the following categories: public health facilities (hospitals, health centres and dispensaries), private health facilities (hospitals, medical centres, medical clinics, maternity and/or nursing homes), faith-based health facilities (hospitals, medical centres, clinics and/or nursing homes), medical training institutions (universities, tertiary colleges), civil society organisations (NGOs/CBOs, relief/humanitarian agencies) and Individuals (patients, guardians, relatives).

Data was collected using structured questionnaires, interview guides and observation check lists. A total of 103 respondents (73 women and 29 men, with one person not revealing their gender) of different reproductive ages were interviewed using structured questionnaires. A total of seven FGDs were held (one in each identified areas identified) in Mombasa, Murangá, Kitale, Kakamega, Garissa, Kijijado and Kibera. Separate FGDs were held with youth (males and females separately), women, representatives of religious groups and general members of the public. In total 47 (21 public and 26 private) health facilities were visited across the six regions and key informant interviews conducted with medical superintendents in charge of the facilities and/or the matrons in charge of the maternity departments.

d) Public Hearings

The public hearings were spearheaded by a panel⁶ composed of five experts, comprising of three KNCHR commissioners and two external consultants. The panellists listened to evidence from individual and group victims and/or witnesses of violation of reproductive health rights from the different regions of the country between June and August 2011.

The target groups of the public hearings included the following categories of people;

- Individual members of the public;
- Groups of private individuals;
- Distinct minority groups/ sections of the communities (sexual minorities, women with disabilities, elderly mothers, young/ adolescent mothers etc);
- Individual professionals/experts on sexual and reproductive health issues;
- Representatives of health institutions;
- Government officers (drawn from the two ministries of Health);
- Representatives of medical training institutions; and
- Representatives of civil society organisations working in the health sector.

⁶ Commissioner Winfred O. Lichuma (Chair) Commissioner Samuel K. Tororei, Commissioner Ann K. Nguni, Prof. Japheth K. G. Mati and Dr (Phd) Owuor Olungah – (See annexure for panelists professional citations)

The hearings further engaged different categories of people in a dialogue on issues around sexual and reproductive health rights. In total, seven public hearing forums were held, six of them in the regions where the field interviews had been undertaken and the seventh bringing together experts in various subject areas identified as key to the subject of the Inquiry.

i. Pre-hearing discussion forums

Each of the six regional public hearings was preceded by a one day pre-hearing discussion forum that was used to sample the witnesses and prepare them for the actual hearings based on the nature of the violations. These enabled the teams to obtain credible witnesses for the actual hearings panels. The forums were attended by those witnesses identified from each region who had engaged in a public discussion where they shared their experiences on the different violations of their sexual and reproductive health rights. Based on these discussions, the most credible witnesses were identified to testify to the Inquiry panel during the actual public hearing sessions.

ii. National Experts forum

At the conclusion of the regional public hearings, a three day forum involving selected experts on selected critical matters of sexual and reproductive health rights arising from the pre-hearings and the actual hearings was held in Nairobi. The forum brought together a total of 34 participants who included professionals and representatives of health facilities and civil society organisations. The experts were brought in to bridge gaps on thematic areas that had been identified at the end of the public hearings.

These included:

- Social-cultural factors;
- Abuse and neglect in health facilities;
- Finance and budgeting ;
- Complaints mechanisms;
- Policy implementation;
- Special groups (LGBTI, Sex workers, students/adolescents, Persons With Disabilities).

e) Submission of Memoranda

The Inquiry team made a public invitation to individuals and institutions to submit written memoranda on a wide range of issues on sexual and reproductive health.

The scope of memoranda included:

- Personal experiences with sexual and reproductive health services;
- Cases of sexual and reproductive health rights violations;
- Laws, policies, and human rights standards relating to sexual and reproductive health;
- Adequacy of sexual and reproductive health care services in health facilities in Kenya;
- Social, economic and cultural factors that prevent people from accessing sexual and reproductive health care services;
- Discrimination of vulnerable groups in accessing sexual and reproductive health care.

A total of 34 memoranda were submitted to the Inquiry team in form of formal discussion or research papers. Other submissions were made in form of recorded statements, email, website/blog articles, video recordings, video documentaries and photographs.

f) Media campaign

A vigorous media campaign was mounted- via both print and electronic media- throughout the Inquiry for publicity and awareness creation. It involved the following:

- Organising a media breakfast meeting that consolidated a working collaboration between the media and the Inquiry team/KNCHR during the Inquiry period;
- Media coverage of key activities of the inquiry including the formal launch of the Inquiry and the pre-hearing forums;
- Placing media advertisements of key Inquiry activities such as the regional public hearings and calling for submission of memoranda;
- Dissemination of public education information through publication of relevant information in the mainstream print media and participation in radio talk shows.

The media campaign also incorporated an interactive e-debate via the internet, particularly the KNCHR reproductive health Blog⁷. The media campaign was designed to achieve multiple goals including mobilisation, public debate/feedback, civic education, monitoring and dissemination of Inquiry findings.

g) Report Writing

The final component of the Inquiry process involved the compilation of the findings into a report, its validation, publication and dissemination. For quality control and to ensure stakeholder participation in the process, a peer review and stakeholder validation workshop was held prior to the publication of the report.

1.5 Report Overview

This report is organised in eight chapters. The first chapter gives the background to the Inquiry and outlines the objectives of the Inquiry. It also discusses the methodology used in the Inquiry. The second chapter contextualises sexual and reproductive health rights (SRHR) in Kenya by highlighting the international, regional and national human rights treaties and commitments that underpin SRHR. The chapter also examines the obligations of government relating to SRHR that stem from these treaties and identifies ways through which international development commitments can influence the realisation of SRHRs.

The third chapter discusses the extent of access to family planning in Kenya by analysing the trends in family planning, the various barriers to accessing family planning services and the international, regional and national policy and legal frameworks that guarantee the right to family planning in Kenya. The chapter makes recommendations on how to realise the right to family planning. Chapter four discusses the status of maternal health rights in Kenya by analysing trends in maternal health and various barriers that result to maternal mortality and morbidity. The chapter further discusses the various regional and international and national commitments regarding maternal health and ends with recommendations on how to guarantee maternal health in Kenya.

⁷ KNCHR National Public Inquiry on Sexual and Reproductive Health available at <http://reproductivehealthinquiry.blogspot.com/> accessed 25th October 2011

Chapter five discusses the nature, forms and consequences of sexual violence. The chapter also assesses the causes of sexual violence and the barriers to access to remedies by victims. The chapter also looks at the various international and regional and national frameworks on sexual violence and ends with recommendations on how to curb sexual violence in Kenya. Chapter six discusses the sexual and reproductive health concerns of sexual minorities including the barriers to accessing essential SRH services by this vulnerable group. It also outlines recommendations on how to safeguard the SRHRs of sexual minorities.

Chapter seven discusses the status of SRHRs of selected vulnerable and marginalised groups by assessing their SRH concerns in light of the international, regional and national frameworks that protect and promote their SRH rights. It concludes with a set of recommendations on how to work towards the realisation of the SRHRs of vulnerable and marginalised groups.

Chapter eight wraps up this report by taking a critical look at the financing of the sexual and reproductive health care in Kenya, and putting forward key recommendations aimed at ensuring adequate resource allocation for this sub sector.



'The Inquiry Panel receiving evidence from a witness in Kitale'

Chapter Two

Contextualising Sexual and Reproductive Health Rights in Kenya

2.1 Introduction

This chapter discusses the relevant definitions of SRHR and highlights the international, regional and national human rights treaties and commitments that underpin sexual and reproductive health rights (SRHR) in Kenya. The chapter also examines the obligations of government to fulfilling optimal enjoyment of SRHR that stem from these treaties and identifies ways through which international development commitments can influence the realisation of SRHRs in Kenya. The chapter presents the basis against which successive chapters of this report will analyse the extent to which Kenya has fulfilled its domestic and international obligations on the fulfilment of the right to sexual and reproductive health.

2.2 Meaning of Sexual and Reproductive Health Rights

Various definitions of sexual and reproductive health rights have been profiled. However, there is no agreed definition of what encompasses SRHRs as their realisation is premised upon the realisation of those rights already recognised. For purposes of this inquiry however, the definition of the United Nations International Conference on Population and Development-Cairo (ICPD) of 1994 was adopted.

“Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have

8 United Nations (UN) Programmes of Action of the international Conference on Population and Development (1994) (online) available at <http://www.unfpa.org/icpd/icpd-programme.cfm> accessed 22 September ,2011.

the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents.”⁹

The ICPD 1994 further elaborates that **reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Reproductive Health Care is also further defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Specific rights relevant to sexual and reproductive health as provided in various treaties include the right to¹⁰:

- Highest attainable standard of health;
- Life and survival;
- Liberty and security of the person;
- Freedom from torture, cruel, inhuman or degrading treatment;
- Decide freely and responsibly the number and spacing of one's children and to have the information and means to do so;
- Have control over and decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination and violence;
- The same right of men and women to marry with free and full consent;

9 Report the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Doc. A/CONF.171/13/Rev. 1(1994).

10 Cook, R J, Dickens, B.M., Fathalla, M F. (2003) Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law. Oxford University Press.

- Enjoy the benefits of scientific progress and its application and to consent to experimentation;
- Privacy;
- Participation;
- Freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health status, disability);
- Access information;
- Education;
- Freedom from violence against women.

2.3 Commitments in International and Regional Treaties on SRHR

Sexual and reproductive health rights are among the most sensitive and controversial issues in international human rights law, but are also among the most important. 11 These rights are guaranteed in various treaty documents and other instruments which clearly delineate government obligations to protect these rights. Implementation of these rights at the regional level is shaped by the socio- cultural beliefs and practices that determine the extent to which the rights are respected, protected and realised. These beliefs either violate or protect individual's rights.

The key international and regional human rights treaties and other instruments, that Kenya is a party to, that provide for SRHR are outlined in the sections below.

2.3.1. International Treaties

- Covenant on Economic, Social and Cultural Rights (1966);¹²
- Covenant on Civil and Political Rights (1966);¹³
- Convention on the Elimination of all forms of Racial Discrimination (1966);¹⁴
- Convention on the Elimination of all forms of Discrimination against Women (1979)¹⁵

11 Paul Hunt and Judith De Mesquita on 'The Rights to Sexual and reproductive Health available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/TheRightsToSexualHealth.pdf accessed on 25th October 2011.

12 ICESCR available at <http://www2.ohchr.org/english/law/cescr.htm> accessed on 21st October 2011.

13 ICCPR available at <http://www2.ohchr.org/english/law/ccpr.htm> accessed on 21st October 2011.

14 CERD available at <http://www2.ohchr.org/english/law/cerd.htm> accessed on 21st October 2011.

15 CEDAW was adopted on 18th December 1979 and entered into force on 3rd December 1981. Kenya acceded to it on 8th April 1984 available at <http://www.un.org/womenwatch/cedaw/cedaw> accessed on 20th September 2011.

- The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984);¹⁶
- Convention on the Rights of the Child (1989);¹⁷
- Convention on the Rights of Persons with Disabilities (2006).¹⁸

2.3.2. Regional Treaties

- The African Charter on Human and Peoples' Rights (1981);¹⁹
- African Charter on the Rights and Welfare of the Child (1990);²⁰
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa or the "Maputo protocol (2003)."²¹

2.3.3. Other Instruments/Commitments

- United Nations World Conference on Human Rights (Vienna 1993);
- Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women (1995);
- United Nations Millennium Development Goals (2000);
- Abuja Declaration (2001) on HIV and AIDS, Tuberculosis (TB) and other related Infectious diseases;
- The Solemn Declaration on Gender Equality in Africa (SDGEA) (2004);
- The Maputo Plan of Action on Sexual and Reproductive Health and Rights of operationalisation of the Continental Policy framework on Sexual and Reproductive Health and Rights (2006);
- The African Health Strategy (2007-2015);
- Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) (2009);
- The African Union Summit on Maternal, Infant and Child Health and Development (2010).

16 Convention against Torture; Adopted on Dec. 10, 1984, G.A. Res. 39/46, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (entered into force on 26, June 1987 available at <http://www.hrweb.org/legal/cat.html> and accessed on 19th October 2011.

17 Convention on the Rights of the Child; Adopted on Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess. Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989) and entered into force 2nd Sept. 1990 available at <http://www2.ohchr.org/english/law/crc.htm> accessed on 18th October 2011.

18 Convention on Persons with Disabilities; Adopted on 13th December 2006 available at <http://www.un.org/disabilities/convention/conventionfull> accessed on 19th October 2011.

19 The Banjul Charter available at http://www.africa-union.org/official_documents/treaties_%20conventions_%20protocols/banjul%20charter.pdf and accessed on 25th October 2011.

20 OAU Doc. CAB/LEG/24.9/49(1990) http://www.achpr.org/english/_info/child_en.html

21 The women Maputo Protocol available at <http://www.achpr.org/english/women/protocolwomen.pdf> accessed on 25th October 2011.

These international and regional treaties and commitments have been interpreted and expanded through General Comments, Concluding Observations, and Jurisprudence from various Treaty Monitoring Bodies.

Furthermore, Kenya is a state party to various declarations and commitments made both at the international and regional levels relating to SRH. For instance, Kenya has committed to achieving the Millennium Development Goals (MDGs) that build on the achievements of ICPD commitments of 1994. Noteworthy, the goal for universal access to reproductive health was not explicitly included in the MDGs. However, achieving quality reproductive health for all is underpinned within five of the MDGs: MDG 1 (poverty); MDG 3 (Gender equality); MDG 4 (Child health); MDG 5 (maternal health) and MDG 6 (Combating HIV and AIDS and other diseases).

At the regional level, Kenya participated and committed to the 2001 Abuja Declaration in which African leaders pledged to place the fight against HIV in the forefront and commit at least 15 % of government budgets to health care. Despite this commitment, Kenya currently only allocates approximately 6.5 percent of government budget (2010-2011) to health.²²

2.4 National Legal and Policy Framework

2.4.1 Legal Framework

The Constitution of Kenya 2010 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 (Article 43 (a)). It further outlines that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants (Articles 43(2) and 3). In recognition of previously centralised services that have undermined access to services including health services, Article 6 (3) on devolution and access to services lays emphasis on enhancing access to services in rural and remote areas. To guarantee implementation of these rights, Article 21 clearly articulates and directs that every institution

22 Gesellschaft für Technische Zusammenarbeit (GTZ) (2010), "Kenyan Health Sector - Budget Analysis",

has the duty to ensure that the rights are fulfilled and report on the progress made in respect to Article 43.

The Constitution further singles out health care for specific groups such as children and persons living with disabilities in Article 53 article 54 respectively. The underlying determinants of the right to health are also guaranteed in article 43(1) (b-f) and include right to adequate housing, right to adequate food, clean safe water, social security and to education.

Other laws promoting sexual and reproductive health rights in Kenya include the Children's Act, the Sexual Offences Act, and the Prohibition of FGM Act.

2.4.2 Policy Framework

The Kenyan policy framework on SRHR draws heavily from the ICPD 1994. This is reflected in Vision 2030, Kenya's long term development blue-print which articulates the country's development goals including health goals- 'to provide equitable and affordable healthcare at the highest quality standards²³'. The key focus areas in the health sector are access, equity, quality, capacity, and institutional framework.

Operationally, the management of reproductive health in Kenya is currently under the Division of Reproductive Health in the Ministry of Public Health and Sanitation. The main management instrument is the National Reproductive Health (RH) Policy 2007²⁴ being implemented through the National Reproductive Health Strategy 2009-2015²⁵. The goal of the RH Policy is to improve reproductive health status of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels. The government's Annual Operational Plan 3, 2007-2008 (AOP-3)²⁶ established various divisions within the Ministry of Health to be responsible for service delivery in various health related areas, including: Division of Reproductive Health, Division of Vaccines and

23 Kenya Vision 2030 document available at http://www.kilimo.go.ke/kilimo_docs/pdf/Kenya_VISION_2030-final.pdf accessed on 2nd November 2011.

24 National Reproductive Health Policy available at <http://www.drh.go.ke> accessed on 20th October 2011.

25 National Reproductive Health Strategy available at <http://www.drh.go.ke> accessed on 20th October 2011.

26 The implementing instrument for the Second National Health Sector Strategic Plan of Kenya

Immunisation, Division of Malaria Control, National AIDS/STD Control Programme, Division of Environmental Health and Division of Child and Adolescent Health.

Regrettably, maternal mortality ratio increased from 414 per 100,000 live births in 2003 to 488 per 100,000 live births in 2008. There are wide regional variations with Northern Kenya having an MMR estimated at 1000-1,300 deaths per live births due to the fact that 95% of deliveries in the region take place at home with no skilled attendants.²⁷ This high incidence of maternal mortality is an indication that government is way below its commitment as per the Millennium Development Goals- to lower maternal deaths to 175 or less per 100,000 live births. The government has developed a Maternal and neo-natal health road map and strategies including community midwifery to enhance protection and facilitate effective referrals. This National MNH Roadmap²⁸ offers a new and revitalised dimension of efforts of all stakeholders towards mitigating high maternal and new born deaths.

Other specific policies relating to sexual and reproductive health include:

- The 2003 Adolescent Reproductive Health and Development Policy;
- The National Condom Policy and Strategy (2009-2014);²⁹
- The Contraceptive Policy and Strategy (2002-2006);
- The Contraceptive Commodities Procurement Plan (2003-2006);
- The Contraceptive Commodities Security Strategy (2007-2012).;
- The School Health Policy;
- Female Genital Mutilation/Cutting Policy;
- The HIV and AIDS Strategic Plan (2009/10-2012/13);
- The National Reproductive Health and HIV and AIDS integration Strategy-August 2009;
- National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans, October 2007;
- National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya, August 2010.

27 Kenya National Bureau of Standards 2008-09 – Kenya Demographic Health survey preliminary report

28 National Road Map available at <http://www.health.go.ke> accessed on 20th October 2011.

29 Available at <http://www.supportworldwide.org/country-programs/africa/kenya/>

These policies are further elaborated and supported by guidelines, protocols, and other administrative actions such as the National Family Planning Guideline for Service Providers, National Reproductive Health Training Plan 2007-2012, Best Practices in Reproductive Health in Kenya, August 2009 among others.

2.5 The Nature of State's Obligations Regarding Sexual and Reproductive Health Rights

At the outset it is important to note that not all sexual and reproductive ill health represents a violation of human rights. Ill health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty-bearer, commonly a state, to meet an obligation in respect of the rights outlined above.³⁰ In the words of Prof. Paul Hunt (the former United Nations Special Rapporteur on the right to the highest attainable standard of physical and mental health) and Judith Be Mesquita, "the right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements".³¹

In the context of SRHR, the obligation to **respect** requires states to refrain from interfering with the enjoyment of rights occasioned by denying or limiting equal access for all persons to SRH services, for example denying the right to decide on the number and spacing of children through forced sterilisation or limiting sexual minorities' and adolescents' access to sexual and reproductive health information and services. The obligation to **protect** means that states should take steps to prevent third parties from jeopardising the SRHR of others, for instance in designing stringent measures to curb sexual violence and harmful cultural practices. The obligation to **fulfil** requires that states take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realisation of rights.³² Health systems should provide for comprehensive SRH services indiscriminately for all, and states should carry out information campaigns to combat, for example, HIV and AIDS, harmful traditional practices and sexual violence.³³ In addition, the obligation to fulfil requires states to

30 <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G04/109/33/PDF/G0410933.pdf?OpenElement>

31 Rights to Sexual and Reproductive Health briefing paper available at http://www.essex.ac.uk/human_rights_centre/research/rth/docs/TheRightsToSexualHealth.pdf accessed on 25th October 2011.

32 General Comment 14 available at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> and accessed on 25th October 2011.

33 An interview with professor Paul Hunt available at <http://projects.essex.ac.uk/ehrr/V2N1/Hunt.pdf> accessed on 26th October 2011.

adequately invest in health providers' capacities to respect and protect these rights.

The Committee on Economic, Social and Cultural Rights has further elaborated a framework for evaluating health services, goods and facilities in the context of the obligation to fulfil based on the criteria of '**availability, accessibility, acceptability** and **good quality**'.³⁴ This also referred to as assuring reproductive health commodity security (RHCS).³⁵ The role in RH commodities is to ensure the availability of affordable, quality RH commodities to all individuals who need them. Availability and access to RH commodities are not only basic human rights, as established in the ICPD and MDG frameworks, but are also critical to improving related health outcomes, such as maternal health and HIV prevention.

Applying this analytical framework specifically to SRH, such services, goods and facilities must be: available in adequate numbers within the jurisdiction of a state; accessible geographically, financially (i.e. affordable) and without discrimination; culturally acceptable to, for example, minorities and indigenous peoples, as well as sensitive to gender and life-cycle requirements, and respectful of confidentiality; and scientifically and medically appropriate and of good quality.³⁶

States are obliged to fulfil SRHR 'progressively', depending on the resources available to them.³⁷ This obliges states to show that they are making 'measurable progresses towards the full realisation of the SRHR and to restrain from adopting 'regressive measures'.

It is however critical to note that not all the rights to SRH are subject to "progressive realisation". There are also various obligations of immediate effect, for instance, the obligation to respect an individual's freedom to control his or her health and body and the obligation to ensure freedom from discrimination and from torture, cruel, inhuman and degrading treatment.

34 General Comment 14 Right to Health, para 12 available at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> accessed on 20th October 2011.

35 Reproductive Health Commodity Security [RHCS] is the ability of all individuals to obtain and use affordable, quality reproductive health commodities of their choice whenever they need them. RHCS is designed to honour, protect and promote the choices of all individuals in exercising their human rights to sexual and reproductive health.

36 Hunt Paul and Judith de Mesquita on Reducing Maternal Mortality available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/reducing_mm.pdf accessed on 26th October 2011.

37 CESCR, Article 2(1)

Further, the Economic Social and Cultural Rights (ESCR) Committee has identified core obligations, relevant to SRHR, that states are required to fulfil immediately.

These include:³⁸

- The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- Provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- Ensure equitable distribution of all health facilities, goods and services;
- Adopt and implement a national public health strategy and plan of action;
- Ensure reproductive, maternal (pre- and post-natal) and child healthcare;
- Take measures to prevent, treat and control epidemic and endemic diseases;
- Provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; and
- Provide appropriate training for health personnel, including education on health and human rights.

2.6 Human Rights-Based Approach Framework in Sexual and Reproductive Health

A human rights-based approach recognises the existence of rights and reinforces the capacities of duty bearers (usually the government) to respect, protect and fulfil human rights. The approach calls on the government to fulfil all rights based on the principles of inclusion and non-discrimination calls on participation and empowerment of the rights holders (boys, men, girls and women) and also provides for holding duty-bearers accountable to fulfil their human rights obligations. The right to health including reproductive health care is subject to progressive realisation. A human rights-based approach to reproductive health recognises that all human rights are universal, interrelated, indivisible, and interdependent and are inherent in all human beings. It acknowledges that sexual and reproductive rights

³⁸ General Comment 14, paras 43-44

cannot be realised without the realisation of other broader human rights, for example, the right to information, privacy and confidentiality and education.

This Inquiry used a human rights based approach framework to assess the extent to which the government of Kenya is fulfilling sexual and reproductive health rights and how it has set its priorities to improve service delivery through various policies and legislations that meet international standards. The human rights analysis assessed the availability, accessibility, acceptability of the highest quality standard of reproductive health as set out in General Comment No. 14 of the Committee on Economic, Social and Cultural Rights.³⁹ Further the human rights based framework assisted in establishing how an enabling policy and legal framework helps to promote, protect and fulfil sexual and reproductive health rights, the access and utilisation of SRH services and information by vulnerable and disadvantaged groups.

³⁹ See General Comment 14 available at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> accessed on 10th July 2011.



'KNCHR staff interviewing a respondent during the inquiry'

Chapter Three

Access to Family Planning Services and Information

3.1 Introduction

Family planning is a key intervention for improving the health and wellbeing of women and their families. It provides couples and individuals the means to prevent unwanted pregnancies and time the formation of their families. Family planning has wide-ranging benefits for sexual and reproductive health, including enabling women to exercise choice and control over their fertility; reducing maternal and perinatal morbidity and mortality; reducing the risk of STIs, including HIV transmission; advancing gender equality, and increasing women's opportunities for education, employment and full participation in society.⁴⁰

The World Health Organisation (WHO) includes access to family planning services in its definition of what constitutes the universal access to SRH services. In its working definition, WHO defines universal access to SRH services to include prevention, diagnosis, counselling, treatment and care services relating to: antenatal, prenatal, postpartum and newborn care; family planning services including infertility and contraception; elimination of unsafe abortions; prevention and treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc. and the promotion of healthy sexuality.

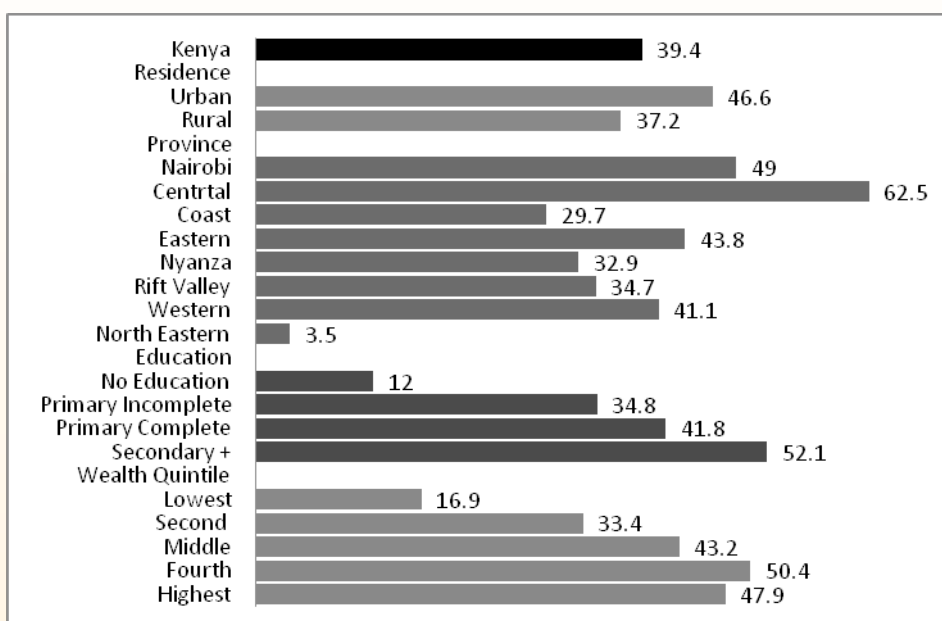
This chapter analyses the status of the right to family planning in Kenya. It begins with an analysis of the trends in family planning, discusses the various barriers to accessing family planning services and discusses the international, regional and national policy and legal frameworks that guarantee the right to family planning in Kenya, while identifying the gaps. The chapter outlines recommendations on how to realise the right to family planning in Kenya.

40 Cohen, 2008; Population and Sustainability Network, nd; CATALYST Consortium, 2004)

3.2 Trends in Family Planning

Kenya's Family Planning (FP) Programme was established in 1967, a pioneer step in sub-Saharan Africa, which saw the contraceptive prevalence rate (CPR) among married women in Kenya rise from 7% in 1979 to 17% in 1984, 27% in 1989, and 33% in 1993. However, between 1998-2003, CPR levelled off at 39% with wide regional as well as social strata differentials. This has since changed; the Kenya Demographic and Health Survey (KDHS) 2008/9 has demonstrated a rising trend, with CPR reaching 45.5% for use of any method and 39% for use of modern methods of family planning. While the current increasing trend is encouraging, CPR is still more than 20 percentage points short of the target of 70% for 2015 (NRHS 2009-2015). Should the rising trend in CPR be sustained, there is a possibility of attaining the projected figure by 2015. As shown in Figure 3.32, use of FP increases with place of residence, level of education, and wealth quintile.

Figure 3.1 Percentage of married women currently using modern contraceptive methods by background characteristics



Source: KDHS 2008/9

The KDHS 2008/9 demonstrates that there is widespread desire among Kenyans to plan their families. Almost 54 percent of all currently married women either did not want to have another child or had already been sterilised, while nearly 27 percent would like to wait two years or longer before their next birth. Notably, even if the CPR

seems to have gone up in the most recent decade, the total unmet need for family planning has remained high (see table 3.1 below), increasing from 24 per cent in 1998 to 26 percent in 2008. This has largely been attributed to inadequate service provision, poor access due to persistent family planning commodity insecurity, low levels of empowerment and decision making amongst potential users as well as limited resource allocation.

Table 3.1: Unmet Need for Family Planning 1998-2009

Survey year	FP unmet need- Spacing (%)	FP unmet need- Limiting (%)	Total Unmet Need (%)
1998 KDHS	14.0	9.9	23.9
2003 KDHS	14.4	10.1	24.5
2008-9 KDHS	12.9	12.8	25.7

Noteworthy, levels of unmet need decline steadily with increase in the level of education and wealth status.

Since 1998, use of long acting and permanent contraceptive methods (LAPMs), the most reliable contraception for spacing or limiting, has shown a declining trend. Table 3.2 shows the trends in Family Planning uptake and patterns of method-mix as reported in three surveys between 1998 and 2009.

Table 3.2: Trends in Uptake of Family Planning and Method-Mix among Married Women aged 15-49 (1998-2009)

	KDHS 1998	KDHS 2003	KDHS 2008-9
Currently using any method	39	38.3	45.5
Currently using any modern method	31.5	30.5	39.4
• Female sterilization	6.2	4.3	4.8
• Pill	8.5	7.2	7.2
• IUCD	2.7	2.4	1.6
• Injectables	11.8	13.8	21.6
• Male condoms	1.3	1.2	1.8
• Implants	0.8	1.6	1.9
• Traditional methods	7.5	7.8	6.0

3.3 Barriers to Accessing Comprehensive Family Planning

A number of factors hinder access to family planning services in Kenya. This section presents the factors identified by witnesses during the Inquiry. The factors are categorised into commodity insecurity, socio-cultural barriers, and costs.

3.3.1 Unavailability of Family Planning Commodities

This Inquiry established that unavailability of family planning commodities is the greatest barrier to accessing comprehensive family planning in Kenya. This is illustrated by frequent stock outs of commodities. There were complaints of frequent shortages of various contraceptives which denied clients a wide choice of FP methods. Long acting contraceptive methods, particularly Implants and Depo Provera were reported to be periodically out of stock.

Female witnesses at the Inquiry who gave testimonies complained of unavailability of family planning services within their reach or that the preferred contraceptives methods were not offered at the nearest health facility.

3.3.2 Structural Barriers

Some women cited structural factors such as the lack of approval of village community health workers to carry emergency contraceptives or directly offer injectables as key factors deterring timely access to FP services. In addition, most long term and permanent methods are not at all or regularly offered in lower levels of health care such as dispensaries and health centres. Yet, for most women, these facilities are the most accessible sources of SRH services. Women complained of being asked to wait for scheduled in-reach health programmes or are referred to distant higher level facilities to obtain IUDs or sterilisation, causing delays in receiving the services and increasing the risk of unintended pregnancies. Testimonies indicated that 'emergency contraceptive' or 'morning –after pill' were not readily available to women in public health facilities. They complained that they had to resort to procuring them at exorbitant prices in commercial outlets such as pharmacies.

3.3.3 Cultural and Social Barriers

The cultural beliefs and practices around child bearing and decision

making authority among African societies were cited as impacting on access to family planning services. The Inquiry heard that men were especially a key hindrance to uptake of FP services. It emerged that, among highly motivated women, who desire to use contraception, most were denied from accessing the services by their spouses. As such, a few resorted to using those methods, such as injectables, that are perceived to be 'highly discreet'. The Inquiry was informed that such methods can be used without the knowledge of the spouse, an assertion confirmed by women from North Eastern region, the nurses from Sisters Maternity Home (SIMAHO) and the District Medical Officer of Health for Mandera East and Lafi.

A retired nurse now volunteering with SIMAHO noted thus:

"Most women practice family planning without the knowledge of their husbands and go for Depo because it is discreet. This is because of the stand taken by their husbands regarding the use of family planning. We however deal with the side effects such as severe bleeding, irregular bleeding or lack of it. We are now even giving implants since they are effective for longer periods than the other methods and can be concealed."

The Inquiry also learnt that discovery by husbands that their wives had been on a family planning method without their knowledge and approval often led to violence and separation/divorce.

The male resistance to the use of family planning was attributed to their firm belief that children are god given, and that it is only god who can determine the number of children one should have. In such communities (for instance the Sabaot and Bukusu of Western Kenya and the Muslim communities in North Eastern) women are required to give birth to as many children as they are able to conceive without exercising choice. It is also notable that it is amongst these communities that girls are married off early in life and therefore women tend to have a longer reproductive life span. Polygamy is a common practice in these communities and wives are expected to compete for the man's resources through child bearing.

The cultural norms that place decision making authority regarding reproduction on the man and in some cases the mother-in-law were also cited to greatly deny women the right to access family planning services. The Inquiry heard that in most communities in Kenya, it is the man who decides whether or not the woman should

use family planning. Similar authority is vested on the mother-in-law, where she determines if, and when their daughters-in-law can use contraception. The mother-in-law also makes decisions as to where the daughter-in-law can obtain health care services. For instance, among the Giriama, a witness reported thus:

*“Giriama culture puts a lot of power in the hands of the mother-in-law who is responsible for giving guidance on which traditional birth attendant (TBA) (**Mkunga**) to be seen and what traditional herbs are to be taken.”*

Further, among the Duruma community, women must seek clearance from their husbands to go to the clinic and are at times not even allowed to visit their neighbours. The practice branded ‘*mwenyewe*’ is a situation where women believe that a husband must be involved in and consulted on health care matters of the woman and children. In addition, the man determines what cultural practices pregnant women must undergo.

The Inquiry was also told that in other cultures, the use of family planning is perceived as an attempt to conceal unfaithfulness and extra marital relations. Hence, a married woman or man seeking family planning is scorned upon and viewed as a person of loose morals or as a commercial sex worker. A male witness in Kitale referring to condom use and family planning noted thus:

“Condoms are only used on prostitutes and this at times leads to quarrels at the family level since women think that the husbands [who use condoms] are unfaithful and as men, we think that women who are using contraceptives [condoms] are up to no good since they can cheat on their husbands without being caught.”

The cultural beliefs were also cited to have influenced the provision of family planning services in Kenya. It was noted here that within the scope of family planning services and information, men are positioned as passive actors, resulting in lack of information and knowledge among men on family planning. Noteworthy, most family planning clinics do not envision men as potential clients and thus design their services/programs exclusively for women, resulting in low male utilisation of these services. In addition, male-based methods such as male vasectomy are stigmatised as culturally inappropriate.

Further, among couples that desire to use contraception, the men tend to advocate for the female based method irrespective of the health and social circumstances the women are in. Among women using FP, a few of them complained of enduring intolerable side effects due to their health conditions, yet their spouses are unwilling to accept male based methods.

Noteworthy, in all the panel hearings, women expressed their desire to space their children and confirmed that they were aware of the risks posed by short birth intervals to both the mother and the newborns. They however felt powerless to determine when to conceive due to unequal power relations and the cultural norms in their communities

3.3.4 Lack of Accurate Information on Family Planning

Misinformation around family planning was cited to be endangering the lives of some women. It was reported that some women have been lured into partaking of herbal concoctions in a bid to plan their families, only to end up pregnant and experience multiple miscarriages and other life threatening conditions like bleeding.

One woman from Sabaot testified to the inquiry panel as follows:

"My husband was a prominent man with six wives. He did not allow any of the wives to use family planning methods. I got a total of 11 children. I tried Depo injection for a short period because he would not discover. It made me bleed continuously for three months and I stopped. A neighbour introduced me to some herbal medicine for family planning. I conceived about three times while drinking the medication and suffered miscarriages. I opted not to use any method until I got to menopause."

Witnesses to the Inquiry spoke about the politicisation of the family planning agenda in terms of population control and growth. In some communities, the political leaders promoted increasing population size as a means of securing political power particularly amongst communities commonly referred to as 'small tribes'. The political leaders were therefore accused of discouraging citizens from using contraceptives.

3.3.5 Unaffordability of Family Planning

The cost, real and perceived, of family planning commodities or services was raised during the Inquiry as an issue of concern. As one witness during the Coast hearing noted:

'I cannot use family planning because I do not have the money to pay for the services'.⁴¹

During the Experts' Forum, Family Health Options of Kenya⁴² noted that the 'issue of cost is a hindrance' for young people in accessing family planning services and unit costs for family planning commodities or procedures vary between facilities.⁴³

According to the study, **'Failure to Deliver'**, which informed the basis of this Inquiry, costs associated with more long term methods are a key hindrance to access to family planning services. The study noted that women regularly encountered formal and informal user fees when accessing contraception; at both public and private facilities.⁴⁴ This is despite government policy that contraceptives at government facilities and government-supplied contraceptives at private facilities must be offered to clients free.

There were reports that clients paid some fees when accessing FP services and that some times it was difficult to directly link these fees to FP services. For example, clients' itemised bills were described as: "administration fee"; "laboratory tests"; "the consultation fee"; or "fee for the FP commodity" such as pills. At times, there would be no charges placed for consultation. In other cases, the Inquiry learnt that when government stores ran out of stocks of commodities, the health facilities sourced commodities from the private sector such as whole salers and distributors and passed the costs to clients. The Inquiry was informed that private facilities often charged a 'service fee' for contraception, even when procured free from the government. Noteworthy, most facilities charge for instance a minimum of KSHs. 50 for oral contraception pills and between KSHs. 500-1,000 for an IUD. These findings are further confirmed by those of the KDHS 2008/2009. Table 3.3 below indicates the percentage of current users who did

41 Witness Testimony at Coast Hearings, Mombasa, 17th June 2011.

42 Is a local non-governmental organisation that provides sexual and reproductive health services

43 Family Health Options 2011, Evidence at the Experts' Forum, Nairobi, 23th August 2011 (Simon Wahome)

44 FIDA-Kenya & CRR 2007, Failure to Deliver, p.16.

not pay for method and the median cost of the method for those that did pay.

Table 3.3 cost of modern contraception method

Percentage of current users of modern contraception aged 15-49 who did not pay for the method and the median cost of the method by current method, according to source of current method, Kenya 2008-09						
Source of Method	Female sterilization	Pill	IUD	Injectables	Implants	Male condom
Public Sector						
Percentage free	54.1%	30.8%	57.2%	16.4%	35.6%	70.8%
Median cost [KSH]	2,495 KSH	18 KSH *		30 KSH	196 KSH	*
Private medical sector/other						
Percentage free	28.00%	3.5%	8.0%	5.0%	6.4%	11.7%
Median cost [KSH]	2,497 KSH	23 KSH	997	90 KSH	996 KSH	10 KSH
Note: Costs include consultation costs, if any. For condom, costs are per package; for pills, per cycle. For sterilization, data are based on women who received the operation in the 5 years before the survey. Numbers in parentheses are based on 25-49 unweighted cases; an asterisk denotes a figure based on fewer than 25 unweighted cases that have been suppressed. Median cost is based only on those women who reported a cost.						

Source: KDHS 2008/9

Worth noting is that these barriers persist in spite of Kenya's commitment to fulfil sexual and reproductive health rights relating to family planning. These commitments are stipulated in the various international, regional and national legal and policy frameworks discussed in the section below.

3.4 Legal and Policy Frameworks on Family Planning

Kenya has committed to fulfilling the right to family planning through a number of international, regional, and national legal and policy frameworks. This section discusses the provisions under the various frameworks that Kenya has ratified or put in place that give effect to the right to family planning.

3.4.1 International and Regional Legal and Policy Frameworks

The ICPD vision includes equality between women and men in reproductive decision making, voluntary choice in determining the number and timing of one's children, and freedom from sexual violence, coercion and harmful practices.⁴⁵ It further recognises the rights of men and women to information and to have access to safe, effective, affordable and acceptable methods of family planning and of their choice.⁴⁶ The Beijing Platform of Action on the other hand noted that lack of sexual and reproductive health education, including family planning, has profound impact on women and men.⁴⁷

The Convention on Elimination of all forms of Discrimination against Women (CEDAW)⁴⁸ in Article 12 promotes the right to health, including family planning. State parties are called upon to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services including those related to family planning. The CEDAW Committee in its concluding observation on the 7th Kenyan periodic report urged Kenya to improve access to reproductive health care based on CEDAW general recommendation No. 24 on the right to health.⁴⁹

45 United Nations (UN), Programmes of Action of the international Conference on Population and Development, 1994, <http://www.unfpa.org/icpd/icpd-programme.cfm> accessed 22 September 2011.

46 Programme of Action of ICPD Cairo 1994; Para 7.2 <http://www.unfpa.org/icpd/icpd-programme.cfm> accessed 22 September 2011.

47 See Paragraph 74 and 106 (e) of the Beijing Platform of Action available at <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf> accessed on 12th November 2011.

48 CEDAW was adopted on 18th December 1979 and entered into force on 3rd December 1981. Kenya acceded to it on 8th April 1984 available at <http://www.un.org/womenwatch/cedaw/cedaw> accessed on 20th September 2011.

49 Para 37 of the report CEDAW/C/KEN/CO/7

Article 10 of the International Covenant on Economic, Social and Cultural Rights⁵⁰ (ICESCR) recognises the assistance to be given to the family which is the natural and fundamental unit of society. Article 10(2) provides that special protection should be accorded to mothers during the period before and after childbirth. Unfortunately Kenya entered a reservation on 10(2) indicating that the circumstances obtaining in Kenya do not render it necessary or expedient the imposition of obligation in this particular article. In the concluding observation of the committee mandated to monitor ICESCR in response to Kenya's periodic report in 2008, Kenya was urged to consider removal of this reservation since it perpetuates violation of women's rights.⁵¹

With regards to the Convention on the Rights of Persons with Disabilities, Article 23(1), requires states to take appropriate measures to eliminate discrimination against persons with disabilities and to ensure that they have the right to decide freely and be responsible on the number and spacing of children and to have access to age-appropriate information, reproductive and family planning education.

The African Charter on Human and People's rights promotes the right of every individual to receive information (Article 9(1)⁵² and the African Women's Protocol requires State Parties to ensure the right to health of women by promoting and respecting the right to choose method of contraception and to have family planning education (Article 14 (1) (c) and (f)).⁵³

In essence therefore, under the international human rights framework, the government has an obligation to respect, protect, and fulfil human rights relevant to family planning. The government is also obligated to ensure a range of family planning goods and services are available, accessible, acceptable and of good quality. The table below summarises the government's obligations with regards to family planning.

50 The ICESCR entered in force on 3rd January 1976 and Kenya acceded to it on 23rd March 1976 available at <http://www2.ohchr.org/english/law/cescr.htm> accessed on 18th October 2011.

51 Para 39 of the concluding observation report E/C. 12/KEN/CO/1

52 The African Charter on Human and People's Rights available at http://www.achpr.org/english/_info/charter_en.html accessed on 12th November 2011.

53 The African Women's Protocol available at <http://www.achpr.org/english/women/protocolwomen.pdf> and accessed on 12th November 2011.

Table 3.4 Nature of government obligation relating to family planning

Availability	The State must ensure that all needed family planning services are made available to boys, girls, men and women in Kenya. All boys, girls, men and women must be able to access information and services at all times and plan when to have children.
Accessibility	The services must be accessed by women, men and the youth (adolescent girls and boys) as a whole irrespective of any difference including disability, sexual orientation among others. The State must ensure that there are no restrictions whatsoever to access the services. The information on costs of FP must be readily available. The FP services must be affordable, thus eliminating any fee barrier to access to contraception.
Acceptability	The existing policies and programmes must be sensitive to all categories of people seeking the services- these include women, men and adolescent's girls and boys. The policies must address the needs of the most vulnerable within the community that include women, persons living with disabilities, marginalised communities living in hard to reach areas, women and men living with HIV and AIDS, LGBTI ¹ persons, commercial sex workers.
Quality	The information that is given at health facilities must be scientifically accurate and respect human rights. The different family planning methods must be made available for all clients to choose from. In cases of conscientious objection, the health providers must be able to refer patients to places where they can get the services so as not to infringe on the girl, woman, boy or man's right to contraceptive information and the services. ²

3.4.2 National Legal and Policy Framework

The Constitution of Kenya 2010 promotes various rights aimed at removing any barriers that hinder men and women from accessing family planning services. The Constitution promotes the right to equality and non-discrimination (Article 27), the right to privacy (Article 31), the right to life (Article 26 (1& 2)), the right to health including reproductive health care (Article 43 (1) (a)), the right to information (Article 35), consumer rights (Article 46), the right to be free from torture or cruel, inhuman or degrading treatment, whether physical or psychological and not to be subjected to any form of violence from either public or private sources. These means that men and women have entitlements that should enable them access family planning and contraceptive services. Progressively Kenya has made positive steps to include these rights in the supreme law of the land and to make the services available albeit not to all men and women who need them. In terms of policy intervention, The National Reproductive Health Policy of 2007 has useful provisions that seek to enhance access to family planning services in Kenya.

3.5 Conclusions and Recommendations

3.5.1 Conclusions

Evidence gathered during the public Inquiry indicates that despite the significant improvement in levels of use of family planning methods in the past decade, there are major barriers in accessing FP services. It is notable that FP services are not universally accessible, available, and affordable. Evidence suggest that gender power inequities, politics, cultural norms and beliefs, lack of accurate information about FP, lack of routine supplies of FP commodities, unavailability of comprehensive FP services in lowest levels of health care system which are most accessible by communities are some of the commonest barriers to accessing FP services in Kenya. Nevertheless, there are many opportunities for the Kenyan government and stakeholders to guarantee access to family planning services to all Kenyans. These are presented in the various international, regional and national legal, policy and institutional frameworks that Kenya is a party to. Implementation of the commitments in these frameworks is therefore imperative to the realisation of family planning rights in Kenya.

Arising from the findings, the Inquiry makes pertinent suggestions on how to work towards the realisation of FP rights in Kenya. These are outlined below.

3.5.2 Recommendations

- Expand access to and demand for a broader mix of family planning methods: The government and other stakeholders should work towards creating high demand for family planning and promote contraceptive use as a health and development agenda. A well balanced method-mix needs to be made available to all people to expand choice in FP. Long acting and permanent methods need to be promoted and made readily available in lower levels of health care delivery such as dispensaries and health centres where most couples seek health care services.
- Promote gender equality as prerequisite for increasing uptake of family planning: There is need to profile gender equality and empowerment as a national development agenda by enhancing capacities for accessing contraceptives and family planning methods for improved health status, reduced maternal deaths and reduced poverty and impoverishment. This calls for integration of gender responsive mechanisms in all health systems. This should aim to ensure that there is no delay or denial of services to women who seek family planning services unaccompanied by their spouses and that spousal consent is never required for a woman to access any family planning services.
- Invest in community structures for effective delivery of FP services: The government and other stakeholders must acknowledge the significant contribution of community health workers in delivery of contraceptives to couples at the village level and invest adequately in this strategy. Evidence available from other countries on successful delivery of injectables and emergency contraception through community based distribution models need to be keenly reviewed and utilised to redesign the community based distribution programmes.
- Eliminate fees associated with access to family planning services in both public and private facilities: This is important in ensuring that everyone has access to comprehensive family planning services and contraceptives irrespective of their ability to pay for the services.

- Address the socio-cultural barriers to family planning with a view to ensure that all persons, including adolescents, persons living with HIV and AIDS, unmarried persons, and persons of all sexual orientations, can access FP services without discrimination. Specifically, government and stakeholders must initiate and/or support advocacy initiatives seeking to transform the socio-cultural and legal barriers women and men face in accessing family planning services and information.
- Family planning initiatives must involve men to ensure that they receive the necessary education and information to be able to make informed choices. As such, the programmes and services need to be reoriented to visibly capture men as actors in the family planning interventions.
- The government and other stakeholders must ensure that Kenyans access accurate information regarding family planning in order to enable them make informed choices. This is also so as to deal with misconceptions, myths and propaganda that often surround the use of family planning.
- The government and stakeholders must undertake rigorous community health education to promote the right to information on family planning. This education should be comprehensive, consistent, and sustained for a long period for long lasting impact and should target both men and women. The government should also promote sexuality and reproductive health education in schools and colleges as is appropriate to different levels. The information on family planning must be readily available, translated in local languages and made user friendly by providing Kenyan sign language interpretation, Braille and other communication formats and technologies so that it is accessed by all who need it.⁵⁴
- The government and stakeholders must fulfil their obligations to ensuring access to family planning services through appropriate planning, adequate resource allocation and implementation of family planning related programmes. The government should ensure the equal and consistent distribution of commodities to all healthcare institutions, both private and public, by streamlining procurement, stock management and distribution of FP commodities.

⁵⁴ See article 7(3) (b) of the Kenya Constitution 2010

- FP services should be integrated within the broader development agenda, beyond the health sector. Stakeholders must therefore promote and integrate FP services with development and well-being programmes such as agriculture, mining and quarrying, and pastoralism, industrial investments, and environment conservations.
- Corporate sector and micro enterprises need to finance family planning programmes for their employees and members through health insurance schemes and other financing mechanisms to motivate increased uptake of FP.
- Government and civil society should lobby the international community to devise and make available low cost brands of family planning commodities with a view to reduce the cost of procuring the commodities.

Chapter Four

Maternal Health

4.1 Introduction

The right to appropriate healthcare services to ensure a safe pregnancy and childbirth is recognised in the International Conference on Population Development Programme of Action. The Committee on Economic, Social and Cultural Rights has further identified maternal healthcare as a 'core obligation' under the Covenant on Economic, Social and Cultural Rights, which states must prioritise immediately.

This chapter presents the Inquiry's findings on the status of maternal health rights in Kenya. It begins by analysing the trends in maternal health and discusses the key determinants. The chapter also details the various barriers that result to maternal mortality and morbidity. The chapter further discusses the various regional and international commitments that Kenya has made to ensure the right to maternal health and outlines the legal and policy framework in Kenya that gives effect to these commitments. The chapter ends with recommendations on what should be done to guarantee maternal health in Kenya.

4.2 Trends in Maternal Health

Kenya is one of the few countries in sub-Saharan Africa where maternal mortality indicators have continued to show a negative trend in the past ten years, with the Maternal Mortality Ratio (MMR) having increased from 414 per 100,000 live births (according to the 2003 KDHS data) to 488 deaths (2008/9 KDHS data). According to the KDHS 2008-09, maternal deaths represent about 15% of all deaths of women aged 15-49 in Kenya. This is approximately 8,000 women dying annually from complications related to pregnancy and childbirth. WHO estimates show that the risk of maternal death is twice greater for women between 15 and 19 years old, compared with women between aged 20 and 24.⁵⁵

⁵⁵ Locoh, 2000

Evidence suggests that maternal morbidity is high, yet it continues to receive less attention compared to maternal mortality. It is estimated that for every woman who dies, another 20-30 women suffer serious injury or disability⁵⁶. Women who survive severe, life-threatening complications often require lengthy recovery periods and may face long-term physical, psychological, social and economic consequences. The death or chronic ill-health of a mother puts surviving children who depend on their mothers for care and emotional support at great risk.

Obstetric fistula (vesico-vaginal fistula-VVF and/or recto-vaginal fistula- RVF which are usually the result of neglected obstructed labour) is one of the most devastating and stigmatised form of complications of childbirth. However, there are others which are equally devastating such as anaemia, infertility, damaged pelvic structure and obstetric paralysis, chronic infection, depression and impaired productivity. Costs of medical care and lost productivity may drive women and their families into poverty. The full magnitude of obstetric fistula problem in Kenya cannot be precisely determined because of inadequacy of data. Nearly ten years ago African Medical and Research Foundation (AMREF) estimated that there were about 3000 new cases of VVF occurring every year (calculated at the rate of 1-2 cases per 1000 deliveries), with only 7.5% of them currently being attended to⁵⁷.

4.3 The Status of Maternal Health Rights in Kenya

The World Health Organisation defines maternal health to refer to the health of women during pregnancy, childbirth and the postpartum period.⁵⁸ As such, the right to maternal health should encompass access to antenatal care services; delivery services, including caesarean section where necessary; essential newborn care services; and post-partum care within two days of delivery. Provision of these services requires availability of trained service providers (midwives, nurses, doctors and clinical officers) at all times and the capacity of facilities to respond to emergency cases, adequate physical facilities, and adequate equipment and supplies including essential medicines and vaccines. According to the NRHP (2007), all pregnant women, including the poor and 'hard-to-reach', should have access to skilled

56 UNFPA Do all pregnant women have the right to live? FACT SHEET: Motherhood and Human Rights, <http://www.unfpa.org/public/cache/offonce/home/factsheets/pid/3851>

57 (Quoted in MOH and UNFPA, 2004 see below).

58 WHO, available at http://www.who.int/topics/maternal_health/en/, accessed on 2nd March 2012

care throughout pregnancy, delivery, postpartum, postnatal periods and care of the newborn. The Policy does not however recognise traditional birth attendants (TBAs) as providers of skilled care.

This section discusses the status of maternal health rights in Kenya by looking at the key indicators essential to the realisation of this right- accessibility, availability, quality, affordability and acceptability.

4.3.1 Extent of Availability and Accessibility of Maternal Health Services

1. Ante-natal care

The inquiry determined that only a small fraction of women in Kenya (7.3%) do not receive any antenatal care (ANC). While these figures are encouraging, certain groups are above this national average, including mothers:

- Under 20 (9.9%) and over 35 (13.3%);
- Having their sixth or more child (14.4%);
- In Rift Valley (10.2%) and North Eastern Districts (28.9%);
- With no education (27.4%);
- In the lowest wealth quintile (14.6%).⁵⁹

Further, less than half of women make the four or more WHO recommended ANC visits and only 7.3% have their first ANC visit in the first trimester (first 13 weeks of pregnancy). ANC services are available in 74% of facilities around the country, a decline from 79% in 2004 (KSPAS, 2010). However, there are regional disparities in this regard as shown in figure 4.1 below.

Figure 4.1: availability of antenatal care

Nairobi	79%	North Eastern	69%
Central	56%	Nyanza	94%
Coast	70%	Rift Valley	74%
Eastern	71%	Western	94%

Source: KSPAS 2010

⁵⁹ Kenya Demographic and Health Survey [KDSH]: 2008/09.

Despite some improvements, the ANC services are still not up to the expected quality standards:

- Around 30% of facilities have all items to support quality ANC counselling services, up from 10% in 2004;
- About 60% have all infection control items, compared to 40% in 2004;
- Over 90% can assure privacy during examinations, however only 30% have an examination light; and
- Only 25% have all five essential supplies for basic ANC services, a decline from over 50% of facilities in 2004.⁶⁰

According to data from the KDHS 2008-09, socioeconomic characteristics including residence, level of education, and wealth, impact the quality of ANC women receive. Noteworthy, women in urban areas, with more education, and in higher wealth brackets, are more likely to receive most essential components of ANC.

During the Inquiry, witnesses raised a number of issues regarding ANC services as follows:

- Failure to provide crucial information and advice to women with histories of high risk pregnancies;
- Lack of maternity waiting facilities (shelter) where women can be lodged waiting to go into labour, as well as failure by midwives to monitor women in such maternity.

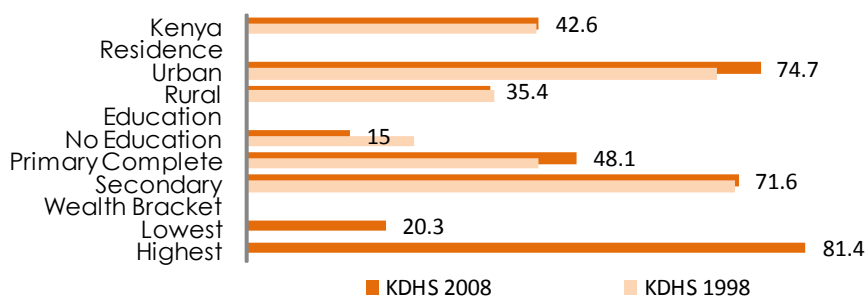
2. Delivery care

Only two out of five births in Kenya are delivered in a health facility—a slight improvement since 1998.⁶¹ Disparities in access to delivery services are stark. A woman in the highest wealth bracket is four and a half times more likely to deliver in a health facility than a woman in the poorest wealth quintile. This is further demonstrated in figure 4.2 below.

⁶⁰ Kenya Service Provision Assessment Survey [KSPAS] 2010.

⁶¹ KDSH 1998, 2003, 2008/09.

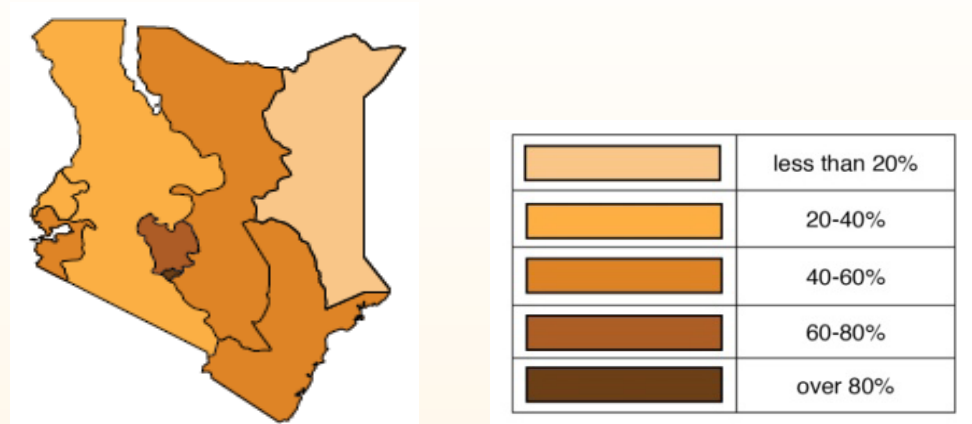
Figure 4.2: deliveries in health facility, by background characteristic.



Source: KDHS 1998, 2008/09

As shown in the figure above, these disparities have not changed significantly since 1998. For some groups, the number of deliveries in health facilities actually decreased. Further, regional disparities with regards to access to delivery services are apparent as shown in figure 4.3 below.

Figure 4.3: deliveries in a health facility, by province



Source: KDHS 2008/09

Regarding availability of delivery services, only three of every ten facilities offer services for normal deliveries. While services for normal deliveries are almost universally available in hospitals, and widely available in maternity facilities and health centres, only 4% of clinics offer normal delivery services.

The physical accessibility of delivery services is also an issue of concern. As the figure 4.4 below demonstrates, significant percentages of the population must travel long distances to access health facilities.

Further, on average, only one half of facilities have transportation support for maternity emergencies—with only a third of the clinics having such transportation support.⁶²

Figure 4.4: Percentage distribution of communities by distance to nearest health facility

	500m or less	500m – 1km	1.1kms – 2.9kms	3 – 4.9 kms	5 or more kms
Kenya	4.9	6.4	12.4	28.5	47.7
Rural	3.0	4.4	12	29.0	51.5
Urban	23.3	25.5	15.9	23.7	11.9
Nairobi	-	10.9	8.2	60.7	20.2
Central	5.7	6.2	16.0	43.4	28.6
Coast	3.7	6.2	13.0	16.9	60.3
Eastern	1.5	5.2	2.3	27.2	63.8
North Eastern	3.2	3.5	7.7	-	85.7
Nyanza	0.1	7.8	11.6	36.8	43.7
Rift Valley	10.6	6.7	17.0	17.7	48.0
Western	5.7	6.3	14.4	28.6	45.0

Source: Basic Report—KIHBS 2005/06

From the figure 4.4 above, it is notable that people, especially from the North Eastern region, have to cover long distances to access health facilities. This grossly impacts on their access to delivery care services. This fact was further corroborated by witness accounts that further indicated that the facilities are often under-staffed and poorly resourced in terms of equipment, capacities and supplies.

The facilities were also said to be inaccessible to those with disabilities. It was noted that various units of health facilities were inaccessible due to difficulties with physical movement and communication within health facilities.

3. Emergency obstetric care

Evidence from the Inquiry revealed that facilities in rural areas were ill equipped to handle emergency deliveries. Women who needed C-sections in small facilities died and/or their babies if they could not

⁶² KSPAS 2010

be transferred in good time. According to the KSPAS 2010, of those facilities offering normal delivery services, only half have additional medicines and supplies to treat common complications.

Blood was not readily available in hospitals banks and the central control policy of blood in the country was said to be a barrier to quality and timely blood transfusion services.

4. Post-natal care

The Inquiry hearings recorded complaints of lack of adequate postpartum care services. Upon discharge, women were not adequately informed how to manage the wounds if they became septic, how to clean them or manage any complications that arose thereafter. The 2008/9 KDHS data shows that less than half (47%) of women receive postnatal care (PNC). However, this represents a significant increase, from 19% in 2003. Most women receiving PNC receive it within the recommended two days from delivery. However, there are wide regional disparities. For example, 79% of new mothers in North Eastern region do not receive postnatal care, compared with 18% of new mothers in Nairobi.

5. Abortion and post-abortion care

Unsafe abortions are reportedly frequent in most Kenyan communities. The World Health Organisation (WHO) defines unsafe abortion as “a procedure for terminating unwanted pregnancy either by a person lacking the necessary skills or an environment lacking minimum medical standards or both.”⁶³ Unsafe abortions in Kenya are estimated to cause 35-50%⁶⁴ of all maternal deaths. These rates are particularly high when compared with global estimates (estimated at 13%).⁶⁵ The most recent data estimates that approximately 21.6 million unsafe abortions occurred globally in 2008, with almost all of them taking place in developing countries.⁶⁶ These deaths are easily preventable. An article in Lancet journal observed that legal

63 World Health Organization, Preventing Unsafe Abortion (2010) available at http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/index.html. accessed on 21st September 2011.

64 A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya; 2004; Ipas in conjunction with Ministry of Health, Kenya Medical Association and FIDA (K).

65 The Alan Guttmacher Institute (AGI) Sharing responsibility: Women, Society and Abortion Worldwide, New York: AGI 1988 and World Health Organization; The World Health Organization, Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 (2011) 1.

66 The World Health Organisation, Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 (2011) 1.

abortion in industrialised nations is one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death."⁶⁷

Lack of safe abortion services in Kenya has resulted in those seeking to procure abortion to resort to crude and unsafe methods, often with dire consequences. A number of women and men who testified before the Inquiry narrated how crude methods were used to terminate unwanted pregnancies by unqualified persons. These included taking traditional herbs or high doses of anti-malarial drugs or strong concoctions of tea leaves, or bleaching solutions. In other cases, women inserted sharp objects such as knitting needles or sticks, through the vagina. Other documented methods include insertion of catheters, pipes, coils or wires, pens and ingesting dangerous substances.⁶⁸ These unsafe methods caused deaths of women and girls or permanently damaged their uteruses; with many of women reporting the inability to conceive again or severe medical conditions that required further treatment and follow-up.

Because abortion is legally restricted, it often occurs underground and therefore is unregulated and subject to prohibitive costs. This hinders women's access to safe abortion services. During the hearings, the Inquiry heard that patients are charged between KSHs. 6,000 and KSHs. 15,000, which for many, is exorbitant. Even when legally entitled to do so, many opt to carry out the procedures by themselves. These assertions were common across the study areas.

According to expert testimony by Ipas Africa Alliance,⁶⁹ at least 2,600 women die from unsafe abortion in Kenya each year.⁷⁰ The high rate of clandestine abortions is attributable to the restrictive laws prevailing in the country. It was noted that a lack of information about Kenya's abortion law, on the part of healthcare providers and

the general public forces women who genuinely qualify for lawful termination of pregnancy, in line with the Kenya Constitution 2010, to resort to unsafe abortions, endangering their own lives. The experts made reference to a case of preventable death due to unsafe

67 David A. Grimes et al, Unsafe abortion: the preventable pandemic, 368 *The Lancet* at 1908 (Nov. 2006).

68 Center for Reproductive Rights; In Harm's Way, the Impact of Kenya's Restrictive Abortion Law

69 IPAS is an international organisation that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. The testimony was given by Dr. Osur and Everlyne Opondo

70 See the Magnitude study by Ministry of Health, FIDA (K), KMA and Ipas 2004.

abortion reported in local dailies in the month of January 2011 in Kenya.

*"A woman aged 40 years who was held in Murang'a police station for allegedly procuring an abortion died after she developed complications. The woman was said to have terminated the pregnancy by swallowing some chemical. She was locked at the police station. Police said she developed complications while at the police station, was rushed to hospital and died en route."*⁷¹

The experts argued that if the police had immediately taken the woman to a health care professional, instead of holding her in remand at the police station, she could have survived. This incident "clearly demonstrates the impact of criminalisation of abortion on women's health and lives", said one of the experts.

In another incident, a mother of seven children procured an unsafe abortion and was arrested. In her mitigating factors, she stated thus:

".....In 'tears'I am a mother of seven and plead for leniency. The children all depend on me for survival. My husband is jobless and landless and we live in a rented room and we are experiencing difficult moments due to inflation. My first born is in standard eight, I procured an abortion because I'm unable to take care of an additional child..."

4.3.2. Quality of Maternal Health Care

Evidence from the Inquiry (witness accounts and reports of non-governmental organizations⁷²) indicates that the quality of maternal health services countrywide remains an issue of concern. The lack of basic supplies such as cotton wool, pads, gloves, syringes, surgical blades, material to wrap babies, anaesthesia, disinfectant, medicines, bed sheets, and blankets; dirty and unhygienic conditions; women forced to share beds or sleep on the floor; and the lack of food and hot water for bathing are some of the key quality issues that have been highlighted. This evidence is further supported by the 2010 \

KSPAS data that found that only 36% of facilities offering delivery services had all the basic delivery room infrastructure and equipment— a bed, examination light, and privacy (both visual and auditory). Shortage of staff, coupled with negative attitudes, lack of supervision,

⁷¹ Daily Nation Newspaper of 18th January 2011.

⁷² FIDA-Kenya & CRR, Failure to Deliver, at 46-48.

was also cited as a factor affecting quality of maternal health services. This section discusses the various factors that undermine the quality of maternal services in Kenya.

a) Lack of supplies and equipment

The public Inquiry was told of lack of essential supplies and medicines, almost routinely necessitating that patients purchase them and overcrowding in hospital wards necessitating the sharing of beds among patients- besides discomfort, overcrowding carries serious risk of cross-infection, not to mention it also interferes with efficiency of professional activities in the wards. Lack of functional laboratory, radiological and ultrasound diagnostic equipment and supplies in public hospitals quite frequently resulted in patients being referred to private facilities, making the services financially unaffordable for them.

The Inquiry was told that facilities in rural areas were ill equipped to handle emergency deliveries. As such, women who needed C-sections in these facilities either died or their children as they could not be transferred in good time.

b) Understaffing and lack of training and supervision

Witnesses at the Inquiry complained of understaffing in most health facilities. Public health facilities were particularly said to be understaffed and under-resourced. Level 2 facilities were especially singled out to be acutely understaffed, leaving the facilities under the care of nurses. It emerged that most government facilities experienced shortage of health care professionals ranging from nurses to obstetricians and gynaecologists. In other cases, the consultant specialists were not available. For example there was only one gynaecologist who served the entire North Eastern region. This region has poor road infrastructure and it's therefore impossible for one specialist to adequately serve the entire region.

Evidence submitted by the Pumwani Maternity Hospital to the Inquiry shows that the Hospital is grossly understaffed. The hospital is operating with 56% nurse capacity and 36% of doctors. The understaffing can be attributed to the unattractive salaries offered by the City Council of Nairobi as evidenced by the 2009 hospital advertisement for medical officers where there were no applicants.

These shortages persist amidst high levels of unemployment of medicine and nursing graduates in Kenya. The UNFPA has observed the paradox of medical staff shortages in Kenya when most graduates in medicine and nursing cannot find jobs. UNFPA in the year 2011 advised that for Kenya to make meaningful progress towards achieving MDG 5, appropriate employment and deployment of skilled midwives was essential.⁷³ Boosting the number and morale of staff is important since there is evidence showing that the density of the health care workforce is a determinant of mortality rates for mothers, infants and children under five.⁷⁴ Kenya has the capacity to train the nurses and other medical practitioners it needs, especially considering that in the period 2005-2009 nearly 2,250 nurses qualified annually from local nurse training institutions.⁷⁵ It is apparent that Kenya's nurse workforce shortage can only be attributed to inadequate employment of qualified nurses as well as poor deployment policies and procedures which interfere with effectiveness and job satisfaction among trained staff. The migration of most skilled medical staff to more developed countries has further contributed to staffing problems.

Witnesses also highlighted the lack of adequate supervision, mentorship and training of the health personnel; inequity in distribution of health providers by region and cadre, as well as negative attitudes and unethical conduct among staff in health facilities - cruelty, absenteeism, and provider reporting to work when drunk - as key factors affecting the quality of maternal health care. Witnesses also complained of delays in being attended to or in receiving treatment at health facilities either because of long queues or due to lack of adequate staff, the sharing of examination equipment among several providers or just because of mere laxity of health workers.

c) Negligence and unethical practices

Witnesses at the Inquiry narrated how they suffered severe injuries in the process of delivery while some lost their babies during delivery because of negligence by health care providers.

A case of negligence was demonstrated by an account given by

⁷³ UNFPA (2011) *The State of World's Midwifery 2011*, launched in June 2011.

⁷⁴ Anand, S. and T. Barnighausen. 2004. "Human resources and health outcomes: cross-country econometric study." *Lancet* 364(9445): 1603-9.

⁷⁵ Kenya's Health Workforce Training Capacity: A Situation Analysis. Report prepared by the Kenya Health Workforce Project, 2010

the husband to Jackline who died at Maria Immaculata Hospital in Nairobi:

“There was blood all over; she had lost a lot of blood. Blood was being drained into a bucket, the bed was covered with blood, and blood was gushing out from her birth canal like a stream of water. I asked the medics why they could not have put a piece of cloth or cotton wool to arrest the bleeding...they ignored me, at this time, she started shaking vigorously, I held her on my arms, felt her pulse rate and sensed danger. Something was terribly wrong!

I still cry to date. I was not ready for what I saw. Imagine seeing someone you love so much, a person who had become part of your life dying. Worse is the painful fact that her death could have been prevented. What I saw was extremely terrifying. It runs in my mind throughout the day, every day. It gives me a lot of pain and anger against those medics...’

When the Inquiry contacted the doctor consultant who was treating Jackline, he clarified that when he was telephoned, he rushed to the hospital and found she had lost a lot of blood. He begun to prepare her for theatre but there was not enough blood at the hospital. The resident doctor indicated that they had sent an ambulance to Kenyatta National Hospital to get more blood but they were delayed in the morning traffic jam in Nairobi city. Jackline died thereafter due to complications of haemorrhage.

Many of the complaints relating to complications and deaths in health facilities were frequently due to negligence and malpractice⁷⁶, and the majority of these complications were related to obstetric cases. The Inquiry also found out that it is possible that a majority of these complaints were never formally presented to the Medical Practitioners and Dentists Board (MPDB)⁷⁷ for investigation and/or action, and no particular legal suit had been initiated by the time of the Inquiry.

76 Medical negligence is defined as the commission of an act that a prudent person would not have done or the omission of a duty that a prudent person would have fulfilled, resulting in injury or harm to another person (Mosby’s Medical Dictionary, 8th edition). Medical malpractice means bad, wrong, or injudicious treatment of a patient professionally, which results in injury, unnecessary suffering, or death (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition).

77 See (<http://www.medicalboard.co.ke/> for details.

Some of the complaints bring to the fore issues of professional responsibility to patients, including availability when needed and providing adequate information concerning the treatment procedure. Negligent actions by doctors and midwives in the context of delivery included: forgetting items such as surgical forceps or swabs in a patient's abdomen; poorly managed labour resulting in a stillbirth or a mentally handicapped child; maternal morbidity such as obstetric fistula (VVF and RVF) and maternal death.

Witnesses also complained about long waiting periods and delays in getting attended to in health facilities, especially in hospitals. Sometimes this was occasioned by doctors or midwives on call refusing to come when summoned, or due to shortage of staff. An example was given of a woman who waited in the Casualty Department from 5am to 4pm before being admitted to the labour ward, and ended up having a stillbirth.

Also common were complaints of failure to give critical prophylactic treatment, for example, PMTCT for HIV positive mothers or anti-G gamma globulin to eligible Rhesus Negative women.

There were complaints of mistreatment of patients by inebriated medical staff. It was reported that in some cases, health workers demand that patients or their relatives do menial tasks in delivery areas such as sluicing and cleaning items soiled during delivery.

The Inquiry also heard that several women had procedures performed on them without their consent, some of them coming to know about the consequences much later. It emerged that information regarding the services and procedures to be conducted on pregnant women was not readily given to patients or their relatives. Some women remained ignorant of the processes to be performed on them. Witnesses who suffered the consequences told the Inquiry that health professionals ignored them and failed to give them information on risks of medical interventions and procedures.

They were not given an opportunity to actively participate in health care decisions affecting them.

For instance, a woman who had been taken to theatre for removal of an ovarian cyst later discovered she had a hysterectomy carried out. She said thus;

*"I am a married woman, a mother of four girls aged between 7 and 22 years. My husband and I still hoped a boy would come one day. In 2006 I started having abdominal pain and saw a doctor at a Mombasa private clinic where I had a scan which showed I had a cyst in my left ovary and was referred to the Coast Provincial General Hospital (CPGH) for further assessment. However, an appointment to see a gynecologist at the CPGH proved impossible, and I ended up seeing the same doctor privately at Mariakani where I paid KShs. 20,000 in order to 'jump the queue' and receive the services much faster. During the operation, anaesthesia was inadequate and although I could not move, I heard everything they said in that room. The cyst was removed and shown around, and then the uterus was also removed. Back in the ward I had a lot of pain throughout the night, without any painkillers given. The next day I was taken back to theatre for removal of a pack which had been left in my private parts. Later when I saw the discharge summary it stated that the uterus had a fibroid and a hysterectomy was performed. That shattered our hope for another child, perhaps a son. "*⁷⁸

Another woman had a hysterectomy performed, possibly because of intractable post-partum haemorrhage. She said:

"In 1996 when I conceived my son, I saw a gynaecologist who saw me throughout the pregnancy. When I went two weeks past the due date he admitted me at Pandya Hospital for induction of labour, but for three days I had no pains. Labour started on the fourth day but my doctor was nowhere to be found; it was not until the next day that he appeared in the middle of the night and attempted to deliver me with a vacuum. I started bleeding a lot and was taken for a C-section. I got baby boy weighing 4kg. When I was taken back to the ward to rest, bleeding increased

and had to be returned to theatre again. After this second operation, I was very weak. I was jaundiced. But what annoyed me most was that the details of my operations were only made known to my husband when he went to clear the bills, and it was not until three months later that my husband was informed that my uterus had been removed. After some years, my husband left me for another woman and to have more children. I have

⁷⁸ The witness showed the Panel the ultrasound scan and the radiologist's report on it, showing a normal sized uterus and a cyst on the left side.

shied away from entering into relationships since I can't have more children. I contemplated suing the gynaecologist, but another doctor dissuaded me saying whatever was done was to save my life".⁷⁹

d) **Weak Referral System**

Testimonies in all regions revealed that referral systems from one level of facility to another were poor or non-existent. There were also complaints related to the inefficient referral systems in several health facilities that caused considerable delays in obtaining higher level care, at times resulting in fatal consequences. This was particularly a serious problem when it came to referring patients from levels 1 and 2 to appropriate higher level facilities. In some cases, women were transported on wheel barrows by family members or donkey carts. Where hospitals had ambulance cars, the patients or the relatives were required to pay amounts ranging from KShs. 500 to KShs. 3,000 for ambulance services. In situations where people were unable to pay, patients were denied treatment. In other instances, blood was not readily available in hospital banks. The facilities lacked adequate infrastructure to obtain blood for emergency transfusions.

In Tana River for instance, a woman who developed complications after delivering at Wenje Dispensary (level 2) died while waiting to raise funds to fuel a government ambulance to take her to Hola District Hospital. A similar report was given in connection with a maternal death due to lack of transport between Magarini Dispensary and Malindi District Hospital.

In Kuria region, for example, patients at Kehancha District Hospital who needed to be referred to higher level facilities were reportedly required to pay KShs. 3,000 to fuel the ambulance. During the Coast hearings, a resident of Tana River County testified that the nearest hospital was 45kms away and residents were required to pay KShs. 3,000 before the local doctor accepted to call the hospital's ambulance to transport a patient. Patients who needed to be referred to Coast District Hospital from Lamu County were reportedly

⁷⁹ This unfortunate case brings out issues regarding professional responsibility to patients, including availability when needed and providing adequate information concerning what is intended and what has been done in their treatment. From the description of the nature of bleeding this woman had it is possible this was a severe case of placenta praevia or even placenta percreta. The management of the latter almost invariably involves a hysterectomy].

required to pay between KShs. 8,000 and KShs. 10,000 to fuel the hospital's ambulance. In North Eastern Province, neither Wajir nor Marsabit District Hospitals had an ambulance- meaning that families must either hire taxis or use donkeys/ camels to transport patients.⁸⁰ In other incidences, citizens also used lorries ferrying livestock as means of transport in getting patients to the nearest health facilities.

4.3.3 Affordability of Maternal Health Care

Witnesses testified that the high cost of hospital delivery, especially the fees charged at level 4 and 5 facilities, was a key hindrance to accessing skilled maternal health services. For example, the nurse-in-charge at Kayole II health centre noted that women who experienced life-threatening pregnancy complications that could not be handled at the centre often resisted being referred to Pumwani Maternity Hospital because they could not afford it.⁸¹ Findings during the Inquiry indicated that the costs of delivery in public hospitals varied between KShs. 3,000 and KShs. 5,000 for a normal delivery and KShs. 8,000 for a caesarean section, in addition to the daily bed charges that accrue during the woman's stay. In private facilities, fees for a normal delivery varied from KShs. 3,000 in some faith-based hospitals to KShs. 10,000 in for-profit hospitals and as high as KShs. 140,000 for a caesarean section, in addition to daily bed charges. These concerns relating to cost of delivery are further confirmed by the KDHS data of 2008/9, where around 20% of women surveyed cited cost as a reason for not delivering in a health facility, with the highest percentage (34%) recorded in Nairobi.

A witness during the inquiry stated thus:

'Many women deliver at home because they do not have enough money to go to the hospital'.⁸²

Evidence from all regions suggested that the costs of delivery include 'hidden costs' such as costs of equipment, commodities, and select supplies that patients in public hospitals are required to purchase such as cotton wool, gloves, blades, bleach etc. As a witness during the Coast hearing explained:

'Women in Lamu usually plan for pregnancy and delivery.

⁸⁰ Wajir District Hospital 2011, Interview with Superintendant during pre-hearing field visit.

⁸¹ Kayole II Health Centre 2011, Interview during pre-hearing field visit.

⁸² Witness Testimony at Coast Hearing, Mombasa, 16 June 2011.

They prepare slowly; by purchasing and storing for themselves consumables - one item at a time', such as rolls of cotton wool, blades, to ease the overall costs of delivery in a public hospital'.⁸³

During the hearings in Nyanza, a witness recounted her experience of delivering at Bondo District Hospital, where, while in labour, she was asked to pay KSHs. 200 for the fee, she was later asked to buy a blade, and then later asked to buy cotton wool. There were also reports during the Nyanza hearings that mothers were not being treated if they did not carry along essential non-pharmaceutical items. In one of the testimonies during the North Rift hearings, a witness stated that she took her sister-in-law to Kitale District Hospital and deposited KSHs. 500, bought cotton wool and gloves at KSHs. 500 and then also paid a bill of KSHs. 2,125.

Apart from cost of delivery, witnesses also testified that costs for other SRH services were unaffordable; preventing women from getting treatment or even going for follow-up visits due to inability to raise the requisite fee. A number of female witnesses reported health problems resulting from child birth that remained untreated due to costs charged in health facilities. A witness at the Eastern region hearings testified that she had had a breast ailment since the year 2000 and had not received any treatment because she was unable to raise KSHs. 5,000. During the North Eastern hearings, one witness said:

"After having my last child, I developed fibroids in my womb. I was advised by the doctor that I have to be operated. They told me it would cost me KSHs. 20,000. I do not have this amount and yet I desire to have this condition treated."

The prevalence of corruption, especially among hospital staff, in form of bribes and/or patronage, was also cited as a barrier to accessing maternal health services. According to witness accounts from Kitale, corruption in health facilities meant that patients ended up paying for drugs and medicines that ought to be provided free. Similarly, a witness during the Coast hearings who had been diagnosed with an ovarian cyst yet could not access the services had this to say:

"For one to get an operation done quickly at Coast General Hospital one has to pay bribes or know someone because there are long queues, so I left."

83 Witness Testimony at Coast Hearing, Mombasa, 16 June 2011.

4.3.4 Cultural Acceptability of Maternal Health Care

Different communities have different cultural norms and practices regarding pregnancy and child birth which should be taken into account by health care providers while designing and delivering maternal health care services. Failure to take this into consideration has often meant that such communities would not utilise such services. Evidence from the Inquiry indicated that some communities did not utilise skilled delivery services because they went against their cultural norms and practices. For instance, among some communities in upper Eastern and North Eastern Kenya, it is a taboo for male nurses to attend to expectant women, while among the Sababot of Western Kenya, a woman is not supposed to be seen naked by any male 'stranger' other than the spouse. The same practice was cited among the Muslims. A councillor from Lamu in Mombasa County noted thus:

"Among the Muslims, there is a belief that only female health care providers should attend to the women during delivery and even during pregnancy. This in essence makes it difficult for men to allow their wives to deliver with the assistance of a professional, hence high prevalence of home deliveries".

4.3.5 Role of Traditional Birth Attendants in Maternal Health Care

According to the NRHP (2007) all pregnant women, including the poor and 'hard-to-reach', [should] have access to skilled care throughout pregnancy, delivery, postpartum, postnatal periods and care of the newborn. Policy does not recognise TBAs as providers of skilled care. However, the Inquiry findings show that in many parts of Kenya the TBA continues to be the key provider of delivery services. It for instance emerged that in North Eastern region almost 85% of the deliveries take place at home with the help of TBAs. Similar sentiments were expressed in Nyanza and Western regions.

Reasons cited for preference of TBAs include inadequate access to skilled attendants and functional health facilities, unaffordable charges in health facilities, negative staff attitudes, and fear of operative delivery. The high cost in health facilities was however cited as the main reason for using TBA services. Witnesses stated that TBAs charge a modest fee and also accept payments in other forms, not necessarily cash. For example, a number of TBAs that gave evidence in Kitale and Embu stated that they charged up to KShs. 600 for their

services, excluding medicine. However, they offered free services for those who could not afford the fee. TBAs representatives at the hearings were positive that their services saved women in-need of pre- and post-natal care. This service was deemed necessary for those who could not afford hospital fees and those who did not want to undergo humiliation by medical personnel in hospitals.

Cultural sensitivity was also cited as another reason why TBAs are preferred in some communities. It was noted that besides the post-birth rituals and other ceremonies surrounding pregnancy and child birth, TBAs provided their services in a culturally appropriate way and in secure home environments that was in conformity with necessary rituals. The relationship between the TBA and the delivering woman was also long lasting and enduring. For instance TBA from Kisumu County noted that placental burial was a ritual that conferred good omen to the newborn and connected it with the ancestors within the home. She further observed that any poor disposal of the placenta could lead to secondary infertility. Among the Luhya, the placental burial of the first born was to be in the homestead and the first born had to be delivered at home. Further, a single girl had to deliver in hospital since her placenta was not supposed to be buried in the home as it would interfere with their brothers' fecundity. In other situations, TBAs delivered single girls at home so as to compel them to reveal those who had made them pregnant.

Additionally, witnesses reported that home deliveries did not follow strict rules, for example, unlike hospitals; women were allowed to assume whatever position they deemed comfortable when giving birth. The nurses from SIMAHO indicated that some women from the North Eastern region preferred holding onto a rope tied on the rooftop so as to be gravitationally assisted in pushing the baby. Others reported that they preferred sitting and relaxing with their backs on the walls or delivering while in a squatting position. More generally, witnesses indicated that they disliked being confined on a very high bed throughout labour, and being placed in the lithotomic position 'with bright light focused on their private parts'.

Some witnesses were also of the view that TBAs possessed some 'unique' knowledge and skills for delivery that providers in health facilities did not have.

A witness from Bungoma reported thus:

“When I was pregnant with my second child, the staffs at the hospital were unable to deliver me and by the grace of God, there was a TBA nearby who just knocked my chest with her knees and the baby came out. She really assisted me and from then, I have never gone back to hospital for health services. I rely on TBA for the herbs and delivery. I get very disappointed when I hear people talk ill of them. I beg that you get in touch with these TBAs so that you get to know how much they help women. They are the only hope in remote rural villages and irrespective of what the government say or does, they are there to stay.”

Evidence received from four TBAs from Kisumu (Nyanza), Trans Nzoia (Rift Valley), Kitui (Eastern) and Garissa (North Eastern), reveals that TBAs continue to offer services to women, though at a reduced volume, and occasionally in secret to avoid punishment from the government. This may have serious consequences since, unlike previously when the Ministry of Health (MOH) was able to influence their practice through training, they are now entirely unregulated. Yet, the evidence from the Inquiry shows that some of the practices carried out by TBAs present potential dangers to the patients, especially their opinion on which patients ought to be referred to health facilities. For example, some claimed they were experts in the delivery of a retained placenta and therefore they never referred such cases to health facilities. Evidence received from doctors at the referral hospitals on the other hand suggested that a significant proportion of women who died during delivery actually arrived too late, having been delayed under the care of TBAs. For example, a gynaecologist narrated to the panellists the circumstances surrounding the death of four women in May 2011, at the Kitale Level 5 Hospital:⁸⁴

“In the first case, a lady was brought bleeding and there was no blood in the blood bank nor was there any functioning medical equipment for emergency delivery care. The second case, a lady from Mt. Elgon bled since morning, and was transported to the facility on a bicycle. She died on arrival at the District hospital. The third case came from Endebbes. She got into labour and stayed for 3 days while trying to deliver at a TBA's home. She was taken to

⁸⁴ Evidence at the Inquiry sitting at Kitale 12-13 July 2011 by Dr. Geoffrey Kasembeli Obstetrician & Gynaecologist, Kitale District Hospital.

Endebbes but was referred to Kitale District hospital. She died at the door of the theatre 20 minutes after reaching the hospital. The last case is of a lady who died because she delivered at home with help of TBA and the placenta did not come out."

One of the TBAs indicated that sometimes her colleagues delayed transferring patients to hospitals because they feared losing their fee. In addition, she talked of the occasional risks they faced in delivering women who were HIV positive. Another TBA from Eastern region said that the only medical problem she referred to hospital was a case of a breach (a case where the legs of the baby come before the head). A TBA from Garissa County indicated that she did not refer any cases of normal delivery (episiotomy) tears to hospital; she managed the tears by applying herbs and tying the woman's legs together for a week.

4.4 The International Human Rights Framework

4.4.1 Mitigating Maternal Mortality and Morbidity

The component of the right to health as expounded in general recommendation No. 14 of the Committee on Economic, Social and Cultural Rights requires that the services must be available with sufficient health facilities and trained health professionals. The former special rapporteur on health, Prof. Paul Hunt, in his report to the 59th Session of the General Assembly in 2004 noted that health professional-doctors, nurses, midwives, technicians and administrators have an indispensable role to play in the realisation of the right to health if the MDGs are to be achieved.⁸⁵

The State has a duty to ensure that there are adequate numbers of health professionals with well-equipped facilities to offer the services.

There is need to increase the number of providers and to improve their terms of service.⁸⁶ The reproductive health services must be physically accessible without discrimination. It is the right of women to receive adequate care during child birth while at the health facility. The shortage of staff and medical negligence is a violation of

⁸⁵ See report A/59/422 available at <http://www.ifhro.org/information-centre/documents-un-special-rapporteur>

⁸⁶ See General Comment No. 14 para 12 available at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> and accessed on 10th August 2011.

women rights to reproductive health. The Committee on Elimination of Discrimination Against women requires that State parties ensure women have appropriate services in connection with pregnancy, childbirth and post-natal period including family planning and emergency obstetric care.⁸⁷ Reducing maternal death has a clear relationship with the right to the highest attainable standard of health which includes reproductive health rights.

It is the fundamental right of a woman to survive pregnancy – no woman should die giving birth. These rights begin with women having the freedom of making choices about their reproductive health life – when and with whom to have sex, the number and spacing of the children inter alia. Women also have the right to life, right to health, right to non-discrimination and the right to self determination among others. The right to information is very critical in women's reproductive health and arises out of the obligation to fulfil human rights. In General Recommendation 14 of the Committee on Economic, Social and Cultural Rights, the health care providers have a duty to give information and to seek informed consent for treatment and procedures.⁸⁸ The government has the obligation to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.

4.4.2 Preventing of Unsafe Abortion

The World Health Organisation (WHO) has elaborated guidelines for prevention of unsafe abortion and the management of complications.⁸⁹ The treaty bodies that are mandated to monitor various treaties have made concluding observations/recommendation and given

guidance to states on aspects of unsafe abortion. The Committees have framed the issue of inaccessible services for safe abortion as a violation of women's right to life and health.⁹⁰

87 CEDAW General Recommendation 24 available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24> accessed on 2nd August 2010.

88 See General Comment No. 14 of the Economic, Social and Cultural Rights Committee on the right to health available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement> and accessed on 12th November 2011.

89 WHO (1997) post abortion family planning: a practical guide for programme managers, Geneva, WHO and (1999) Interpreting reproductive health. Geneva, WHO and Safe Abortion: Technical and Policy Guidance for Health Systems all available at <http://www.who.int/reproductive-health> accessed on 29th October 2011.

90 The Human Rights Committee has expanded promotion of the right to life to include measures taken by the State to help prevent unwanted pregnancies and to ensure that women do not go through clandestine abortions that violate women's rights. The Committee has given this guidance in interpreting the right to life in General Comment NO. 6 of ICCPR and on General

In the Concluding Observation of the Kenyan 7th CEDAW periodic review, the Committee expressed concern that illegal abortions remain one of the leading causes of maternal mortality and asked the State to consider reviewing the restrictive abortion laws that lead women into seeking unsafe and illegal abortions. The committee regretted that maternal health policies in Kenya do not pay sufficient attention to complications arising from unsafe abortions. Further, the committee was concerned with the high number of teenage pregnancies. It urged the Kenya government to improve access to contraceptives and provide women with quality services for the management of complications arising from unsafe abortion.⁹¹

The Committee on the Rights of the Child has also expressed concerns on high maternal mortality arising from unsafe abortions and the criminalisation of the termination of pregnancies among adolescents that arise from rape and defilement. It expressly recognised maternal mortality due to unsafe abortions as a violation of human rights and recommended to Kenya to increase access to safe abortion services to reduce the incidences of unsafe abortion.⁹² The restrictive law on abortion has equally been criticised by human rights monitoring bodies and Kenya has on many occasions been called upon to legalise and decriminalise abortion.⁹³

4.5 The National Legal and Policy Framework

4.5.1 Mitigating maternal mortality and morbidity

The Kenyan Constitution 2010 provides for economic social and cultural rights in Article 43. It provides for the right to health including reproductive health care and further states that no one should be

denied emergency medical care (Article 43 (2)). The Constitution also guarantees other underlying determinants to the right to health, spelt out in Article 43 (1) (b-f). In order to meet the State obligations, the Ministry responsible for health has developed a Maternal and neo-natal health road map which requires strict implementation. In the recent National Gender and Equality Commission Act, 2011, the Commission is mandated to work with other relevant institutions in the

Comment NO. 28 on equality of rights between men and women and during the human rights committee on Concluding Observation on 2005: See Par.14, U.N. Doc. CCPR/CO/83/Ken (2005).

91 Para 38 and 39 of Concluding Observation report CEDAW/C/KEN/CO/7

92 CEDAW Committee, Concluding Observations, Kenya, Para 38, U.N. Doc CEDAW/C/Ken/CO/6 (2007)

93 See Centre for Reproductive Rights; In Harm's Way; the Impact of Kenya's Restrictive abortion law, 2010 at page 129-132 available at <http://reproductiverights.org/en/resources> accessed on 20th September 2011.

development of standards for the implementation of policies for the progressive realisation of the economic and social rights specified in article 43 of the Constitution and other written laws.

The 2nd National Health Sector Strategic Plan of the Ministry of Health 2005-2010 set to improve service delivery by focusing on improved performance by health care providers and public awareness of clients' rights.⁹⁴ Among the initiatives proposed included training and enhancing service quality by initiating regular clinical audits (in particular for maternal deaths) and building them into performance management systems. On the demand hand, the Ministry plans to have the Citizen's Health Charter with clear information on services and procedures offered, encouraging respect for complaint procedures, encouraging participation of men in reproductive health, and training health workers on client handling and patient centred approach.

The National Reproductive Health Policy, 2007 appreciated that the strength of a health system is a key determinant of the quality of services it offers. It sought to review the staff norms and build their capacities, train and supervise providers at all levels, transfer clinical skills through use of modern methods and deploy service providers skilled in sexual and reproductive health care at all levels in line with the health sector strategic plan.

At the African Union, Member States have been encouraged to dedicate more resources to the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) as a strategy for the integrated, multi-sectoral and multi-agency promotion of Maternal, Newborn and Child Health.⁹⁵ Kenya launched CARMMA on 9th November 2010 -reiterating the Campaign's slogan that "no women should die while giving life" (birth). The first Lady, through a speech read by the Minister for special programmes during the launch, highlighted the need to improve the attitude of midwives as it had been shown that mothers were reluctant to go to facilities due to bad treatment they received.⁹⁶ Kenya acknowledges that

94 Reversing the Trends-the Second National Health Sector Strategic Plan of Kenya-NHSSP II-2005-2010 available at <http://www.nacc.or.ke/attachments/article/102/NHSSP%20II-2010.pdf> and accessed on 12th November 2011.

95 African Union Commission. Actions on Maternal, Newborn and Child Health and Development in Africa by 2015 available at http://afhea.org/Docs/Final_20DECLARATION_2012_205_2009.pdf accessed on 12th November 2011.

96 UNFPA African Regional Office on Status of the CARMMA Launch Report March 2011 available at <http://www.unfpa.org> accessed on 13th November 2011.

continued maternal mortality reflects a serious developmental deficit considering that maternal health is a key measure of the health systems' capacity in a country and that the health of a mother is the backbone of the family and the community. That when the mother dies, the fabric of the whole family is shattered and leads to poor health outcomes of the spouse and children.⁹⁷ Kenya has however made slow progress towards realisation of the MDG 5 aimed at reducing maternal mortality. The regrettably slow MMR progress between 2003 and 2008/09, largely attributed to low uptake of maternal services, is of concern. Although the proportion of births attended to by skilled attendants increased from 42% in 2003 to 43.8% in 2008/09, there was evidence of less than half of the births being delivered at health facilities. Other factors associated with the increase of maternal deaths included poverty, limited physical access to health facilities, limited skilled delivery and poor client management, poor referral systems, and high prevalence of negative socio-cultural practices such as FGM⁹⁸

Prof. Miriam Were in her submission to the panel on how to improve reproductive health services in Kenya proposed that the Community Health Strategy would be the best entry point. She said this will empower communities and families as the basic units of decision making. She proposed active male participation in matters of reproductive health and shaping cultural beliefs and practices of different communities. "If women are empowered, they will take care of their health including reproductive health," she observed. She concluded that the Community Health Strategy of the Ministry of Public Health and Sanitation must find an innovative way of linking TBAs to the formal health care system since the TBAs have played significant roles where formal health care system was absent.

The MoH Strategic Plan 2008-2012 highlights human resource as a key area of intervention. However the evidence received during the hearing still point to the fact that the issues of understaffing, lack of appropriate skills, poor staff attitude, low morale and weak external supervision systems persist. These undermine delivery of maternal health services and violate the rights of the people seeking such services.

The National Reproductive Health Policy 2007 prioritised a number of

⁹⁷ Millennium Development Goals -The status Report for Kenya – 2009; June 2030 available at <http://www.planning.go.ke> accessed on 14th August 2011.

⁹⁸ Ibid

interventions relating to improved safe motherhood and maternal and neonatal services: ensuring right to reproductive health information to all, increasing both comprehensive and basic emergency obstetric care to meet minimum standards, ensuring referral networks across public and non-public facilities are promoted, and strengthening capacity of community-owned resource persons (CORPS) including TBAs - to enable them play designated roles such as promotion of birth preparedness, early identification and referrals of complications, post-natal care and registration of births. However, evidence from the Inquiry indicates that the government has not fully implemented these priorities.

4.5.2 Preventing Unsafe Abortion

The Kenyan Constitution 2010 has relaxed the rigidity on termination of pregnancy that existed previously. The effect of Article 26 (4) of the Constitution of Kenya 2010 is the repeal of the restrictive abortion laws and policies of Kenya that existed before the promulgation of the new Constitution, thus section 158-160 and 214 of the penal code. Article 26 (4) permits safe abortion if in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law. Article 26 (1) of the Constitution protects the right to life and Article 26 (2) does further provide for when life begins; thus at conception. These articles repealed section 214 of the criminal procedure code that had earlier provided that a child becomes a person and capable of being able to live when out of the mother's womb.

The Penal code previously criminalised the attempt to procure a miscarriage by a third party (S. 158), the attempt to procure a miscarriage by the woman herself (159) and the supply of drugs to procure a miscarriage (160). These carried a heavy penalty of 14 years, 7 years and 3 years in prison respectively. However surgical abortions when the procedure is performed for the preservation of the mother's life was exempted and therefore legal (S. 240).

Further, the Medical Practitioners and Dentist Board's Code of Professional Conduct and Discipline⁹⁹ provides that the law of Kenya does not allow for termination of pregnancy on "demand" and severe penalties are to be meted out to members of the profession

⁹⁹ Code of Professional Conduct and Discipline (5th Edition), MPDB Circular No. 4/79, revised in May 2003 at pg 16

found guilty of procuring or attempting to procure an abortion or miscarriage. However the health practitioner has room to undertake safe abortion in the interest of saving the life of the mother and the baby as legally provided for in the Penal Code. The advice given by the code was that the practitioner consults with at least two senior and experienced colleagues, obtains their opinion in writing and performs the operation openly in hospital. The same provision is in the code of ethics of Nurses and Clinicians.

The experts from Ipas expressed concern that one year after the promulgation of the Constitution, none of the health regulatory bodies (the Kenya Medical Practitioners and Dentist Board, the Nursing Council of Kenya, Clinical Officers Council and the Pharmacy and Poisonous Board) had reviewed their codes of regulations to align them to the new provisions of the Constitution under article 26 (4).

Noteworthy, although Kenya has now relaxed the laws regarding abortion, the move is still not in line with international obligations that require that women are empowered and have the self determination to decide when, how and with whom to get children. On 8th October 2010, Kenya ratified the Maputo protocol but again, in an unprecedented move, entered a reservation on Article 14 (2) (C) disallowing legal abortion in cases of rape and defilement and where the life and health of the mother and foetus are in danger. This is inconsistent with article 26(4) of the Constitution 2010. There is no indication from the proposed plan of implementation of the

Constitution submitted by the Ministry of Health to the Inquiry that safe abortion services will be made available at all county levels as legally provided for under Article 26 (4) of the Constitution. This thus calls for the need to sensitise the Ministry of Health that the scope of availing services for termination of pregnancies should be within the circumstances defined in the Constitution and as such, services must be made available in both urban and rural areas including the marginalised areas.

4.6 Conclusions and Recommendations

4.6.1 Conclusions

Evidence from the Inquiry demonstrates that Kenya has failed to address the well known factors and barriers that perpetuate high maternal mortality and morbidity. Factors such as poor quality of

maternal health services, high cost of care, weak referral systems, inadequate capacity in terms of personnel and facilities to provide care, negligence and malpractices among health providers, socio-cultural barriers among others have over time colluded to perpetuate maternal mortality and morbidity. Restrictive laws and lack of policies and programmes on safe abortion have also significantly contributed to the high maternal mortality and morbidity in Kenya. The inquiry concluded that women continue to die or suffer disability due to preventable causes.

These factors prevail against the backdrop of the myriad international and regional human rights frameworks and commitments that Kenya is a party to and the national legal, policy and institutional frameworks that are aimed at enhancing maternal health.

From the foregoing therefore, the Inquiry concludes that Kenya is still far from realising the maternal health rights as stipulated in international and regional human rights frameworks to which it is a party and in accordance with its domestic laws and policies.

The Inquiry thus makes a number of recommendations to government and other stakeholders that are essential in working towards the realisation of maternal health rights in Kenya. These are outlined below.

4.6.2 Recommendations

1. Mitigating maternal mortality and morbidity

- The government must work towards implementing the Human Rights Council resolution on preventable maternal mortality by adopting a human rights based approach to all interventions aimed at reducing maternal mortality and morbidity. This will empower people to participate in decision making and policy development. It will also strengthen the capacity of the duty bearers to give services and the rights holders to demand their rights and hold the duty bearers accountable.
- The Ministry of Health should work out a clear implementable strategy for the Constitutional provisions on the right to health including reproductive health and the underlying determinants as provided in Article 43 of the Constitution. The Strategy must seek to make the services available and accessible, of high

quality standards, affordable and culturally acceptable.

- Government and stakeholders should rethink the accountability mechanisms that seek to record deaths occurring from preventable causes with a view to make them effective. In which case, the strategy should seek to record these deaths as they occur and indicate their causes.
- The government must work out a strategy to address all the five known and identified sources of delays that eventually lead to maternal deaths:
 - a) Time it takes to recognise that a woman is facing life threatening health complications - this delay can be eliminated through educating the community on how to identify life threatening signs in an individual that require emergency interventions;
 - b) Time it takes to make the decision to seek services - this can be eliminated through sensitising men and other persons that influence health seeking behaviour at community level;
 - c) Time it takes to travel in search of the services – strengthening the referral system by improving the infrastructure, especially the transport system. This will require involvement of the decision makers (Parliament and now County Committees) to address poor infrastructure and allocate enough resources for transport in the health sector;
 - d) Time taken to receive the services upon arrival at a health facility- this should entail the improvement of the capacity and effectiveness of health care professionals in giving services. This can be achieved through training, providing adequate equipment and supplies and recruitment of adequate personnel;
 - e) The failure by the government and donors to affectively address the issues of maternal mortality – this would entail increased resourcing and prioritisation of maternal health issues. Noteworthy, with the establishment of devolved county governments, there are opportunities for the government to effectively address the problems relating to geographic access to maternal health care. In which

case, the county governments need to devise innovative approaches to ensure the 'hard to reach' areas can access health services and that the vulnerable members of the society, such as disabled persons, are identified and provided with adequate maternal and child health care services. Further, the Community Health Strategy (2006) presents an opportunity for extending maternal health services to the grassroots (Level 1), but this requires establishment of robust and efficient referral mechanisms in order to ensure prompt access by Level 2 and 3 facilities.

- The new County governments need to address the problem of congestion in referral hospitals. This can be achieved by adequately equipping lower-level facilities to handle all cases they were designed to handle and reduce the number of cases they refer either due to shortage of skilled providers or essential equipment. For example, in Nairobi, there are several Level 3 facilities where normal deliveries can take place, including four that were recently upgraded to Level 4.
- As County governments are established, staffing levels will need to be reviewed as well as commensurate remuneration packages to ensure quality services in compliance with international treaties and the Constitution of Kenya.

2. Strengthening health systems

- The referral systems need strengthening as a mechanism for ensuring effective linkages between the different levels of the health care system, from community level to the highest referral facilities managed at the county level. Strengthening referral systems is particularly urgent considering that lack of functional ambulance service was a common feature in many testimonies during the Inquiry. A strengthened referral system is particularly crucial for transfer of emergency cases that require life-saving procedures such as caesarean section.
- The government and other stakeholders must work towards universal access to maternal health care. This implies that a health financing mechanism that ensures that each person is able to afford maternal health care services should be put in

place. As such, the government should adopt the proposed social health financing scheme that seeks to ensure access to health care for all.

- As the government sets to implement the 2010 Constitution, there is need to ensure that health facilities at all levels of government are adequately equipped to provide quality maternal health services. This means that all facilities must be well equipped to manage emergency deliveries, C-sections, termination of pregnancy and provide other maternal health services.
- The government and other stakeholders should implement (where standards exist) ethical standards and guidelines that govern medical practice with a view to eliminate cases of mistreatment in health facilities and medical negligence and malpractice that often result in maternal morbidity and mortality. The codes of practice must incorporate the obligations of health care providers to the patient and also outline the rights of the patient. Clear penalties in cases where the provisions are not adhered to must be spelt out. The codes of practice and standards must be based on international human rights standards and the Kenyan Constitution 2010.
- The Health Professionals' various codes of ethics should be reviewed using a human rights framework with a view make them compliant to human rights standards and principles.
- The government must make it mandatory that all health facilities establish complaint mechanisms. To facilitate this, government should issue guidelines on how these should be established. These are important in enabling clients forward their complaints to the relevant authorities for action in cases where they feel violated. Further, the government should compel all facilities to post information on patients' rights in visible settings in healthcare facilities along with information about how a patient can file a complaint.
- There is urgent need to increase the number of health care providers, especially those dealing with maternal health care, across the country. This means that, the government should

recruit and train more health personnel with a view to address the current shortage that is being experienced in the country.

- The MOH must roll out the Community Health Strategy as it provides the best entry point in improving maternal health in Kenya. This would empower communities and families as the basic units of decision making. Active male participation in matters of reproductive health and shaping cultural beliefs and practices of different communities is critical. Noteworthy, empowering women would ensure that they take care of their health including reproductive health. The Community health strategy must find an innovative way of linking TBAs to the formal health care system since the TBAs are playing a significant role where formal health care system is absent.
- Referral facilities need to establish functional community outreach health programmes with a view to ensure that maternal health care services are availed at the community level. This will help in identifying all women in need of maternal health services and the types of care that they need.

3. Health education

- The government and other stakeholders must embark on a comprehensive education and awareness programme targeting communities, schools, healthcare institutions and other key players - on the maternal health rights as stipulated in the Constitution 2010 and international and regional human rights frameworks that Kenya is a party to. This is essential in enhancing the capacities of duty bearers to provide maternal health services and the rights holders to demand for the services.
- Government and other stakeholders must intensify health education at the community level with a view to influence the uptake of maternal health services within the community and the households. Such education must particularly target community level decision makers including men and mothers-in-law with a view to ensure that they positively influence health seeking behaviour and reduce some of the delays leading to maternal deaths.
- The MoH and health professional training institutions must ensure

that health care professionals are trained or re-trained and re-oriented to respect the dignity and rights of persons seeking maternal healthcare services.

- Stakeholders should seek to empower women regarding their maternal health rights with a view to enable them make independent informed decisions. Women empowerment programmes should adopt a holistic approach seeking to promote livelihood, rights, and health well being. Such programmes should integrate male involvement so as to capture male responsibility and participation in promoting gender equality for improved maternal health.

4. Promoting safe abortion

- The Ministry of Health and other stakeholders must develop standards and guidelines to operationalise lawful termination of pregnancy as provided in the Constitution 2010 and in line with international human rights frameworks that Kenya is a party to. The guidelines and standards must be taught and disseminated in all health professional training schools and to health workforce.
- All health regulatory bodies in Kenya should review their codes of practice and ethics on termination of pregnancy in line with Article 26 (4) of the Constitution. It should be made clear that healthcare providers cannot deny abortion services in emergency situations because of their personal objections and that post-abortion care services cannot ever be refused because of provider's personal objections.
- The government, at the county level, must make available safe abortion services in all the health facilities. Specifically, the facilities designated as capable of delivering safe abortion services must have staff trained to counsel and provide abortion services and at least one such staff member must be on call to ensure twenty-four hour availability of these services. Further, all healthcare facilities at the county and national levels must be well equipped to provide emergency post-abortion care services.
- Abortion services must be made affordable to all those who

need them. As such, the government should integrate provision of abortion services into the broader health financing policy and strategy.

- Kenya must deposit the instruments of ratification of the Maputo protocol with the African Union Secretariat. In addition, it should withdraw the reservation placed on Article 14 (2) (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women¹⁰⁰ in conformity with its obligations under the new Constitution.
- The MoH, together with organisations promoting and protecting maternal health rights must undertake civic education on Article 26(4) of the Constitution 2010 with a view to enhance uptake of safe abortion services, especially by those who are legally entitled.
- The MoH should also ensure that the Constitutional provisions on abortion are taught in all health training schools and that trained health professionals are aware of the circumstances under which abortion may now be legally provided. The MoH should further ensure that health practitioners including clinical officers, nurses and midwives are trained - both pre-service and in-service - as necessary on how to provide safe abortion services and post-abortion care.
- The Ministry of Internal Security and Ministry of Justice, National Cohesion and Constitutional Affairs should together ensure that police officers are trained on the Constitutional provisions on abortion so as to prevent the wrongful arrest and harassment of healthcare providers who offer and women who receive safe and legal abortion services.

¹⁰⁰ Women Protocol available at http://www.wachpr.org/english/_women_en.html accessed on 19th October 2011.



'Kenyans Queuing for RH Services at a health facility'

Chapter Five

Sexual Violence

5.1 Introduction

Sexual violence is seen in domestic law and international human rights frameworks as a violation of the rights of women and girls and boys and men. In Kenya today, the prevalence levels of sexual violence are high, mainly affecting girls and women. These occur against the existence of both national and international legal, policy and institutional frameworks aimed at safeguarding the sexual and reproductive rights of all Kenyans.

This chapter discusses the nature, forms and consequences of sexual violence. It assesses the causal factors of sexual violence and the measures taken by the state and other stakeholders to address the phenomenon. It also examines the various international and regional mechanisms that Kenya is party to that seek to curb sexual violence- an assessment of the national legal, policy and institutional frameworks is also given. The chapter ends with recommendations on how to curb sexual violence in Kenya.

5.2 The Nature and Extent of Sexual Violence

Sexual violence is any act- attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise- directed against a person's sexuality using coercion by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.¹⁰¹

The World Health Organisation indicates that, a wide range of sexual violence takes place in different settings in Kenya¹⁰². These include:

- rape within marriage or dating relationships;
- rape by strangers;
- systematic rape during armed conflict;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;

¹⁰¹ WHO World Report on Violence and Health Available at http://whqlibdoc.who.int/publications/2002/9241545615_chap6_eng.pdf, accessed on 28th February 2012

¹⁰² Ibid

- sexual abuse of persons with physical or mental disabilities;
- sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;
- forced abortion;
- violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
- forced prostitution and trafficking of people for the purpose of sexual exploitation.

According to the 2008-09 KDHS findings that investigated women's experience of sexual violence, including whether the respondent's first sexual intercourse was forced against her will, forced first sexual intercourse is not uncommon among Kenyan women; 12 percent of women aged 15-49 reported that their first sexual intercourse was forced against their will. For women whose first sex encounter was before age 15, they are more likely to report that the intercourse was forced compared to those who initiated sex at an older age. The findings further indicate that one in five Kenyan women (21 percent) has experienced sexual violence. Analysis across regions indicates that the region- Western Kenya - (former Western and Nyanza provinces) with the highest proportions of women experiencing physical violence also have the highest proportions of women experiencing sexual violence. In the vast majority of cases, sexual violence is perpetrated by persons known to the victims; strangers account for only 6 percent of sexual violence. The likelihood of experiencing either physical or sexual violence increases with the age of the women.

Evidence from the Kenya Police Crime Report and Data for 2007 indicates that there were 876 cases of rape reported, 1,984 cases of defilement, 181 cases of incest, 198 cases of sodomy, 191 cases of indecent assault and 173 cases of abduction reported in 2007. In 2008, The Kenyan Police force lists "Offences against morality" as making up 5% of the total reported crimes across the country.¹⁰³

During the Inquiry, witnesses narrated several instances where they had experienced sexual violence. Witnesses from Mt. Elgon and Trans

103 Cited in Kiragu J (2011) Status of Sexual Gender Based Violence in Kenya

Nzoia Districts, Ameru, Kuria, Kisii and the Luo communities reported incidences of sexual violence. For instance, there were reports that sex is often used as a weapon of subjugation even in pregnancy and since they have nobody to complain to, they just endure the abuse.

In Embu, witnesses reported three cases of child defilement and one case of rape of an 11 year old girl with a mental disability. In the North Eastern region, witnesses reported rampant cases of defilement and noted that whenever they happened, they were settled traditionally through a traditional court known as '*maslaha*.'

Incidences of marital rape were also reported, with witnesses indicating that they at times are forced into sexual intercourse by their husbands against their wishes or when they are not ready. The men on the other hand see bride price as an instrument conferring them the blanket consent and exclusive sexual rights over their spouses. There was a consistent feeling among men that marital rape did not exist among married couples, a belief that perpetuates sexual violence against women.

Witnesses also indicated that sexual violence is often heightened by conflicts. They cited incidences of rape and other forms of sexual violence that were targeted at women and girls, men and boys during the post-election violence of 2008 and the crackdown on the militias in Mt. Elgon, noting that these had devastating effects on the victims.

5.3 Effects of Sexual Violence on Victims

Sexual violence has profound effects either directly or indirectly on victims' reproductive health. It may lead to unwanted or unplanned pregnancies that eventually are likely to cause unsafe abortions. Where sexual violence occurs, there are higher chances of contracting STI's including HIV and AIDS. Women also report numerous gynaecological complications arising from sexual violence. Sexual violence results in stigma, psychosocial trauma and majority of the victims adopt the culture of denial, silence and ultimately suffer serious health consequences without seeking immediate health care attention. In extreme cases sexual violence results in death or severe maiming¹⁰⁴.

104 Satima Consultants Ltd, 2009, UNIFEM Report on the Incidence and Prevalence of Gender based violence in Southern Sudan

During the Inquiry, six women from Kibera who were raped during post-election violence of 2008 lamented that they contracted STIs including HIV; suffered physical, emotional, and psychological trauma, became victims of unwanted pregnancies, and were subjected to long term counselling to mitigate the psychological and medical consequences as well as the cultural stigma.

Women who were raped during the Mt. Elgon clashes were also said to have contracted HIV and other STIs and gotten pregnant. A male witness recalling the Mt. Elgon clashes had this to say:

"Women in Saboot were violently raped by both the civilians fighting and the army. They could not access immediate medical attention. The most tragic thing is that they gave birth to children whose biological fathers are not known. Some were infected with HIV. It is a sad state of affairs."

Most of the women who suffer rape are also often rejected/abandoned by their husbands. During the Inquiry, women from Kibera and Mt. Elgon gave painful accounts of how their husbands deserted them after they were gang raped during the post election violence and Mt. Elgon clashes respectively. They lamented how they can no longer take care of themselves and the children.

One woman from Mt. Elgon testified to the inquiry panel as follows:

".....I was in the house with my four children asleep. My husband had joined other men to keep guard outside. I heard the door being forcefully opened. I saw three men dressed in army uniform with well lit touches. They demanded to know where my husband was. I told them he was out. My children were up and screamed. Without any further questions, one slapped me and threw me on the bed. They raped me in turns as my children cried. They left me unconscious....The following day when I managed to gain conscience; I could not go for treatment since nobody was allowed to leave their houses. I was in pain for about three days. Finally I received treatment but tested HIV positive. I am currently on ARVs. My husband walked away on me on learning of my rape ordeal....."

A witness account also demonstrated how women who were victims of rape faced double tragedy. This is summed up by one woman who narrated her ordeal below:

"I was raped by members of a gang as well as the police. I contracted gonorrhoea and the worst part of it all; my husband deserted me claiming that he can never again sleep or live with a woman who has had sex with so many people like that. I am left alone with my three children and my sex life is in shambles."

The Inquiry was also informed of how women and school going girls in the Mt. Elgon region were raped by the police, the military as well as the members of Sabaoth Land Defence Forces (SDLF) during land clashes and the security operations. Some were infected with the HIV virus while others were impregnated. The tragedy is that most of the men deserted their raped wives.

5.4 Factors Perpetuating Sexual Violence

A report on the status of sexual and gender based violence in Kenya, 2011¹⁰⁵, and witness accounts during the hearings demonstrate that the root cause of sexual violence is the historically unequal power relations between men and women and the abuse of this power by men, resulting in the domination over, discrimination against and abuse of women. According to findings of the Inquiry, "the unequal power relations - where laws, policies, community practices and beliefs "conspire" to deprive women autonomy in private and public spheres, higher incidences of domestic and sexual violence are likely to occur". Noteworthy, the low levels of awareness of the law, coupled with social and economic barriers that survivors of violence face, make it nearly impossible for them to exercise their rights. "Inequality renders women vulnerable to violence". The vulnerabilities are further intensified where women are unable to negotiate for safer sex and protect themselves from sexually transmitted infections including HIV/AIDS. Poverty, civil unrest, displacement and harmful cultural or traditional beliefs about women and girls are cited as some of the factors which increase the risk and/or severity of violence for girls and women in Kenya¹⁰⁶.

Findings from the Inquiry further indicate that the culture of impunity in relation to sexual abuse and violation of girls and women is a key factor perpetuating the vice in Kenya. This is rooted in the normalised violation of women in society. Notably, sexual violence

¹⁰⁵ Kiragu J (2011) Status of Sexual Gender Based Violence in Kenya

¹⁰⁶ Ibid

thrives in both conflict and peace situations- where legal frameworks and institutions are functional. Communities uphold, practice and normalise various forms of abuse on women that include female genital mutilation (FGM), early and/or forced marriage and virginity testing. "The value attached to female chastity is so high that even when a woman is a survivor of sexual abuse, the typical community response is to isolate and stigmatise the survivor."¹⁰⁷ The shame and stigma attached to this socio-cultural taboo, and the lenient penalties meted out on offenders in both formal and traditional judicial systems, result in survivors staying silent". For women and girls, the procedures and evidence required to access the justice system are often complex, burdensome and quite humiliating. The low levels of women's empowerment and awareness regarding their rights is a great challenge to their utilising and engaging with legal systems.¹⁰⁸

During the Inquiry, conflicts and breakdown of law and order were mainly cited as the factors perpetuating violence. This was evident from accounts of victims of rape during post-election violence and Mt. Elgon clashes. This was further demonstrated by accounts of witnesses from Kisumu who revealed that rape and defilement were on the increase among the Luos due to break-down of law and order.

Cultural norms were said to foster sexual violence in most communities in Kenya. The inquiry was told that among the Sabao, in situations where rape happens within the community by a known member of the family or clan, elders convene a meeting to resolve and cleanse the victims to avoid shame and stigma in a ceremony known as "to beat the leaves" or 'Kepresogo'.

A witness from Ugunja District further demonstrated how cultural norms perpetuate sexual violence in the area noting that whenever a young girl is sexually abused by a relative, they refer to it as "*Thuol odonjo eko*" meaning that a snake has entered the gourd with milk and whichever way this is solved, there is need to ensure that the gourd is not destroyed nor the milk poured. This in essence means

that no justice is meted out to the victims or any punishment to the perpetrators.

The Inquiry was also informed of a silent cultural practice amongst the

¹⁰⁷ Ibid

¹⁰⁸ Ibid

Duruma in which fathers have sexual intercourse with their daughters before they are married. One of the witnesses from Kinango lamented that these incidents of incest will continue since no one speaks or reports them. Further, a witness from an NGO championing women's rights, the Coast Women in Development, reported that they have dealt with seven cases of sodomy since the beginning of 2011. She attributed the cases of incest, sodomy and sexual impropriety to cultural traditions and drug abuse which are rampant in the Coastal region.

Instances in which people act against the cultural norms and have intercourse of whatever nature with close family members were also reported at the Inquiry. In the Coast region, incestuous relationships were reportedly very common. ICRH¹⁰⁹ reported that coerced sex namely defilement and sodomy were the primary offenses against children in Coastal counties of Mombasa, Kwale, Kilifi, Tana River, Lamu and Taita Taveta and often led to high risk sexual behaviours in later life stemming from emotional and behavioural damage caused at an early age.

Given the secrecy with which sexual issues are handled even with obscure community processes, most community members are not willing to boldly talk about and tackle cases of incest and defilement. This has led to cases where women and girls suffer in silence.

The complex justice system- which is intimidating to the victims/survivors of sexual violence was also cited as a perpetuating factor. During the Inquiry, a woman recalled how her husband defiled her daughter in 2008 yet she has not been able to access justice. She has now separated from him. She said thus:

"My husband was always very drunk and subjected me to beatings; he forcefully had sexual intercourse with me. On many occasions I ran away and slept with neighbours or went back to my parent's home and would return for the sake of taking care of my three children aged ten, six and four. I left the matrimonial home in 2007 and rented a room in Kitale town where I lived with my children and sold cereals at the market. My husband forced himself back to me and claimed that he had reformed. After a short period he was back at it; beating me senseless and one day in 2008 he threatened to kill me. I

109 ICRH, 2010

ran away and he entered the house and locked it from inside. Our four year old daughter was in the room asleep. After a few minutes I heard the child scream loudly and then went silent. I pleaded with him to allow me to take the child but he refused to open the door. After two hours he opened the door and I entered to my dismay, he had defiled our daughter... I reported the matter to the police and he was arrested. I was never informed of the hearing date but I learned that he was acquitted since I failed to appear in court to testify."

5.5 Barriers to Access to Remedies by Victims of Sexual Violence

5.5.1 Lack of One-Stop Facility Where to Obtain Health Services

The Inquiry was informed that integrated services were not available to victims/survivors of sexual violence. Dr. Nduku Kilonzo of Liverpool VCT had this to say:

"Integrated services for treatment of violence survivors would be the way to go. In one facility a survivor should be able to make the complaint, get examined and treated, receive emergency contraceptives, obtain STI and HIV tests and finally the survivor gets engaged in long term prevention measures such as HIV management through ARVs. However, these services are never made available to survivors of violence"

5.5.2 Lack of Awareness of Services that Exist

Lack of awareness of existence of post rape services was also said to be a barrier to access to remedies by survivors. The Inquiry noted that there was very little evidence gathered on existence of post-rape care services and most witnesses were not aware of the major components of post-rape services. Those who were aware of existence of these services could not mention more than one facility where the services were being offered. This is despite the importance of timely interventions required for survivors of sexual violence in terms of speedy medical interventions upon being raped and the need to collect and preserve evidence in order to accurately trace perpetrators of violence and present credible evidence in courts of law.

5.5.3 Difficulties Accessing Documentation to Prove that One Suffered Sexual Violence

The Inquiry noted that one of the difficulties in accessing post-rape services is the lack of documentation to prove that they suffered the rape related violence. Speaking to the inquiry panel, a witness noted that the P3 form (Kenya Police Medical Examination Form) is not easily accessible to all survivors. Most police stations reported lack of enough copies either due to shortages of the P3 forms or the police demanding bribes to prepare the report.

5.5.4 Unaffordable Services

During the Experts' Forum, Liverpool VCT raised a concern over the affordability of post-rape care, especially among women living in slums, rural areas, and in drought stricken areas. The Experts observed that the average cost of post -rape care services is USD 27 (approximately KSHs. 3,000) per outpatient client.¹¹⁰

5.5.5 Burdensome and Humiliating Justice System

Negative attitudes of the police; the hassle and long procedures required to obtain a P3 form (Kenya Police medical examination form); the embarrassment and stigma caused to the survivors during the interrogation period either in the health facilities or police stations and the unwillingness of the health providers to support evidence presented by the survivors were reported as some of the reasons that make access to justice for sexual violence survivors impossible. These factors increase the vulnerability of sexual violence survivors who suffer in silence and thus likely to suffer recurrent violations.

5.6 International Human Rights Frameworks

Numerous International human rights treaties provide that all human beings must have freedom to enjoy their rights to physical and mental integrity and sexual autonomy without discrimination. Though men and women, boys and girls get subjected to sexual violence, the overwhelming majority of cases are related to women and girls as demonstrated by the testimonies received during the Inquiry.

¹¹⁰ Liverpool VCT 2011, Evidence at the Experts' Forum, Nairobi, 24 August 2011 (Dr. Nduku Kilonzo).

CEDAW does not explicitly mention sexual violence but the Committee on Elimination of Discrimination against Women has recommended that states parties should ensure that laws against family violence and abuse, rape sexual assault and gender based violence give adequate protection to all women and respect their integrity and dignity.¹¹¹ However because of the continuing lobbying at the international level, violence against women and sexual violence were incorporated in non-binding declarations namely Vienna declaration and platform of Action (1993) and the Beijing declaration (1995). It is within these declarations that sexual and physical violence have been firmly and explicitly located.

The Vienna Declaration and Platform of Action identified sexual violence as a structural issue, rooted in power and gender relations and experienced by women on a daily basis and may not be defined as human rights in many of the mainstream human rights documents.¹¹²

The Beijing Declaration defines sexual violence to include but not limited to violence occurring in the family within the general community, sexual abuse of female children, marital rape, rape, sexual abuse, sexual harassment and intimidation and sexual violence perpetrated by the State.¹¹³ The Declaration further acknowledges that sexual and other violence against women occurs as a result of embedded social values, cultural beliefs and unequal power relations. It is the responsibility of the state to protect the vulnerability of women and girls from the perpetrators. Complicity of the state is recognised as contributing to the cycle of violence experienced by many women and the failure to punish the perpetrators amount to violations of women's rights.

The CEDAW General Recommendation 19 on 'Violence against Women' defines gender—based violence as a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.¹¹⁴ This is violence directed against a woman because she is a woman or which affects a woman disproportionately. It includes physical, mental or sexual harm

¹¹¹ Ibid 152

¹¹² [http://www.unhchr.ch/huridocda/huridoca.nsf/\(symbol\)/A.CONF.157.23.En?OpenDocument](http://www.unhchr.ch/huridocda/huridoca.nsf/(symbol)/A.CONF.157.23.En?OpenDocument)

¹¹³ Available at <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf> and accessed on 4th February 2012

¹¹⁴ accessed on 19th August 2011.

suffering, threats of such acts, coercion and other deprivations of liberty.

The right to accountability and redress affords everyone the right to effective, adequate, accessible and appropriate education and information on the legislative and judicial and other measures to redress sexual and reproductive rights. Sexual rights have been identified as human rights and they include the right to equality and equal protection of the law, the right to life, liberty and to be free from torture and cruel inhuman treatment, the right to privacy, right to personal autonomy, the right to health and benefits of scientific progress and the right to education and information. The Optional Protocol to CEDAW reaffirms the determination of States parties which adopt the protocol to ensure the full and equal enjoyment by women of all human rights and fundamental freedoms and to take effective action to prevent violations of these rights and freedoms. The protocol introduces another level of accountability for State parties through the provision of complaints mechanism open to individual citizens and to public inquiry by the monitoring committee. However Kenya has to date not ratified the Optional Protocol. Nevertheless Kenya as a State party to CEDAW is obliged to ensure women enjoy all the rights provided.

In the Concluding Observations of Kenya's initial report on Economic, Social and Cultural Rights, the ECOSOC committee was concerned with the incidences of domestic violence and the low number of complaints filed by victims of domestic violence including marital rape¹¹⁵. The Committee made several recommendations including that the State enacts the domestic violence (family Protection) Bill 2000 and other legislation to criminalise domestic violence including marital rape and train the police, prosecutors and judges in the strict application of the criminal procedures as well as considering repeal of Section 38 of the Sexual Offences Act 2006.

5.7 National Legal and Policy Framework

5.7.1 Legal Framework

The national legal framework for SGBV draws guidance from the Constitution of Kenya 2010. Article 27 (3) promotes equal treatment

¹¹⁵ See E/C.12/KEN/Co/1

for men and women, including the right to equal opportunities in political, economic, cultural and social spheres. It prohibits any form of discrimination. The Constitution promotes the right to human dignity for every person (Article 28) and prohibits subjection to any form of violence in public or private sphere (Article 29 (c)). Evidence emerging from the hearings indicates that most cases of sexual violence experienced by women are perpetuated by cultural norms and practices and it is in these private spaces that Article 29 (c) of the Constitution seeks to intervene. For example, among the Somali, most of the cases of sexual violence against women are settled at the community level through 'Maslaha courts' and are not treated as serious criminal offences.

The Sexual Offences Act 2006 (SOA) is the legal and comprehensive framework protecting survivors of sexual and gender based violence. It expands the list of sexual offences legislated against to incorporate offences such as the rape of men, sexual harassment, gang rape, child sex tourism, and child pornography amongst others. Previously, SGBV was covered under the Penal Code¹¹⁶ as common assaults and assaults causing actual bodily harm (Section 250 and 251). Even though to a large extent the Sexual Offences Act has remedied some of the gaps with respect to articulating sexual violence crimes, there are still gaps in protection as marital rape and domestic violence continue to rage unabated and the law has not sufficiently addressed or recognised them as crimes. In addition, certain provisions of the Act have been seen as a hindrance to access to justice by survivors. For instance, testimonies by survivors of rape or defilement indicated that Section 38, which makes it an offence to falsely accuse a person of a sexual offence has discouraged many women and girls from reporting incidences of SGBV. This is in addition to the insensitivity of the judicial system as well as the survivor's mistrust of the judicial system which they perceive as corrupt.

Section 38 of the Act States:

"Any person who makes false allegations against another person to the effect that the person has committed an offence under this Act is guilty of an offence and shall be liable to punishment equal to that for the offence complained of."

The Task Force on the implementation of the Sexual Offences Act submitted a memorandum to the panel highlighting their mandate, achievements and challenges. The Kenya National Commission on Human Rights is a member of the Task Force and is well versed with the mandate of the SOA Task Force. The Task Force has been able to develop the National Policy Framework and Guidelines for the implementation of the SOA and forwarded the same to the Hon. Attorney General for approval. It has also developed Regulations relating to the dangerous offenders database that have been gazetted and incorporated to the SOA. The Medical Treatment Regulations are pending gazettment by the Ministry of Public Health and Sanitation, whilst the Chief Justice Rules of Practice and Procedures are being finalised. The Task Force is in the process of preparing a comprehensive policy and measures for victims/survivors of sexual violence and management of sexual offenders and has developed a position paper on 'one stop centre' referral mechanism for victims of sexual and gender based violence. It has also conducted an audit and review of all existing laws, policies, regulations, practices and customs relating to sexual offences and awaits validation by stakeholders. Finally the Task Force has proposed amendments to SOA including the repeal of Section 38 of the Act and this has been submitted to the Hon. Attorney General for consideration and onward tabling before Parliament. The Task Force further identified challenges hindering fast and smooth implementation of the SOA. These included; high ignorance levels among the citizens of the provisions of the SOA, low funding for the Task Force activities, weak multi-sectoral approach to implement its recommendations, and lack of enough power to push government ministries, departments and the CSOs at large, to fully implement the SOA. The Task Force proposes to establish, within the Act, a permanent coordinating body for administration of the Act to replace the Task Force.

5.7.2 Policy framework

The policy framework in Kenya on sexual violence is governed by the National Guidelines on Management of Sexual Violence. It provides for management of medical, psycho-social, legal and humanitarian aspects of sexual violence with the main goal to ensure the needs of survivors are met. The guidelines acknowledge that sexual violence is a serious health and human rights problem in Kenya that affects men and women, girls and boys. The Guidelines were reviewed following

the wave of serious cases of sexual violence during the post-election violence in 2007/2008 with a view to respond to complex and diverse needs of sexual violence survivors and bridge the gap that existed in legal framework and service provision.

Noteworthy, none of the health workers who testified on their recent experiences in handling or managing cases of sexual violence mentioned being aware or ever using the Guidelines on Management of Sexual Violence. This could be an indication that the medical practitioners are not aware of the Guidelines and therefore their utilisation could be non-existent.

The 2007 National Reproductive Health Policy has identified priority interventions relating to sexual violence to include; interventions to promote gender equity and equality in decision making on matters of reproductive health by having programmes that ensure access to quality treatment and rehabilitative reproductive health services for survivors of sexual gender based violence, promoting male involvement in the reproductive health programmes, promoting empowerment of women in reproductive health decision making, and promoting participation of households and communities in addressing harmful cultural practices. The testimonies received during the Inquiry however show that the priority interventions identified by the Policy have not been adequately implemented

All the legal, policy and other measures notwithstanding, generally, prosecuting sexual violence matters in the Kenyan courts is a daunting task for women. The process causes stigma and embarrassment to the survivors who in many incidences are women. These offences are committed in secrecy and survivors lack direct eyewitnesses to corroborate their evidence as required by the law. On the other hand, police are reluctant to prosecute the perpetrators and instead intimidate women causing them more psychosocial trauma and subjecting them to additional stigma. For men, the inquiry was informed that they are in most cases too are embarrassed to report incidence of sexual or other forms of violence suffered.

5.8 Conclusion and Recommendations

5.8.1 Conclusions

The inquiry noted the continued incidences of sexual violence in Kenya despite the various international, regional and national frameworks that seek to address this phenomenon. It was particularly noted that in spite of the efforts to prevent sexual violence in Kenya, various perpetuating factors persist such as cultural practices, conflict situations occasioned by breakdown of law and order and the continued existence of illegal militia groups, and the impunity by law enforcement officers- especially when restoring law and order in communities.

It is also clear from the findings of the inquiry that survivors continue to experience barriers to access remedies. Some of the common ones identified during the Inquiry include lack of integrated services, lack of awareness of existence, especially of post-rape services, stigma and shame associated with sexual violence, the unaffordable services, the complex and often humiliating justice system among other factors.

In keeping with its international, regional and national obligations, the State must take steps to address the problem of sexual violence with a view to safeguard the sexual and reproductive rights of all Kenyans. Towards this end, the Inquiry makes a number of pertinent recommendations for consideration by the government, the Kenya National Commission on Human Rights and other stakeholders.

5.8.2 Recommendations

Government

- To urgently ratify the optional protocol to CEDAW that will allow citizens to file individual complaints to the Monitoring Committee once they exhaust domestic remedies.
- Urgently repeal section 38 of the Sexual Offences Act as proposed by the Task Force on implementation of SOA.
- Allocate adequate resources to the Sexual Offences Task Force to undertake its mandate in full. The multi-sectoral approach to implementation of SOA may require a permanent body to

undertake the activities and it is recommended that the Hon. Attorney General considers the establishment of such a body within the framework of SOA or in the alternative, assign the role to any of the existing Constitutional Commissions.

- Provide victims/survivors of violence with legal, medical and psychological support, and referrals for specialised medical treatment.
- Remove all barriers that hinder access to justice in respect of sexual violence cases. The delay in preserving evidence and prosecuting sexual violence cases must be abated. The Victims must be enabled to pursue redress without undue delay. The criminal justice system should review and relax the requirements in prosecuting sexual offences especially on the rule of corroborating the evidence.
- The MoH must work with all stakeholders to disseminate and popularise the Guidelines on Management of Sexual Offences of 2009.
- Expand the range of health facilities with capacity to cater for the needs of SGBV survivors throughout the country.
- Undertake clear monitoring and documentation of incidences of sexual violence, especially those occurring in IDP camps, Refugee camps and in all other places of detention and make public the findings.
- The next national reproductive health strategy should put more efforts or emphasis on education and economic empowerment of women as a critical priority strategy for mitigating sexual violence especially among vulnerable groups.
- Undertake an analysis of the cost of sexual violence to the economy – in terms of health care, police and judiciary and other administrative services. This analysis will demonstrate the economic prudence of investing in preventive measures rather than incurring costs in managing sexual violence and its attendant consequences post-facto.

Kenya National Commission on Human Rights and National Gender and Equality Commission and other stakeholders

- Continuously monitor and document cases of sexual violence and seek to hold duty bearers (government) accountable.
- Create awareness on sexual violence, especially the kinds of redress mechanisms in place, the procedures to access redress, the services available among others.

Chapter Six

Sexual and Reproductive Health Rights of Sexual Minorities

6.1 Introduction

Sexual minorities suffer numerous sexual and reproductive health rights violations on the basis of their sexual orientations or behaviour. According to a report by the Kenya Human Rights Commission, '*The Outlawed Amongst Us*', arbitrary arrests, harassment, sexual abuse by police, religious instigated homophobic attacks and difficulty in accessing healthcare services are among the challenges faced by Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) members of the society. This group suffers gross discrimination and stigma owing to their sexual orientation or behaviour.¹¹⁷ This chapter presents the findings of the Inquiry regarding the common challenges faced by sexual minorities namely lesbian, gay, bisexual, transgender and intersex (LGBTIs) and sex workers in accessing sexual and reproductive health rights. The chapter begins by giving an account of the different barriers to access to sexual and reproductive health services by sexual minorities. It also presents the international and regional commitments Kenya has made to-date to protect the rights of sexual minorities and analyses the national legal and policy framework in Kenya that give effect to these commitments. The chapter outlines recommendations on how to safeguard the SRHRs of sexual minorities.

6.2 Barriers to Access to SRH Services by Sexual Minorities

6.2.1 Lesbian, Gay, Bisexual and Intersex (LGBIs)

a) Discrimination and Stigma

Witness accounts indicated that LGBIs are discriminated, stigmatised and subjected to violence because of their sexual orientation. In cases

¹¹⁷ KHRC (2011), *The Outlawed Among Us: A Study of the LGBTI's Search for Equality and Non-Discrimination in Kenya*, Available at http://www.khrc.or.ke/resources/publications/cat_view/37-downloads/40-equality-and-anti-discrimination.html, accessed on 4th March 2012

where they need medical care, they suffer stigma perpetuated by health care providers who breach their privacy and confidentiality by exposing their sexual orientation to other colleagues at the facilities. The health care providers are not friendly and hardly understand their sexual and reproductive health needs.

Another complaint related to stigma is demonstrated by an assertion by a group of LGBIs in their testimony in Mombasa County:

"We are looked at as if we cannot take care of our children and our families want to take them away from us. This is very disappointing as we believe that we are like anybody else."

Further, men who have sex with men (MSM) engaged in sex work find it difficult to reserve hotel rooms due to growing restrictions on checking in as couples. They are also not allowed to access some common utilities in hotels and bars because their presence in these facilities is perceived as discouraging potential regular customers or being recruitment drives for customers to engage in homosexual relationships.

b) Exclusion from decision making processes

Witness accounts indicated that the LGBIs are often excluded from the making of national policies, decisions and guidelines relating to HIV/AIDS and other STIs. This was said to intensify their vulnerabilities to such infections. Lesbians especially noted that they are not included in the category and definition of the Most at Risk Population in Kenya whereas MSMs are included - meaning that their (Lesbians) unique needs are not catered for.

c) Limited access to SRH services

The Inquiry heard that LGBIs have limited access to SRH services such as condoms, gel (for MSM) and dental gums (for Lesbians) yet they are at greater risk of contracting sexually transmitted infections among other sexual and reproductive health concerns. A lesbian witness at this Inquiry stated that as a population category, there is low contraceptive/condom use; practices of multiple sexual partners, high prevalence of HIV and AIDS and STIs; drug and substance abuse including alcoholism; prevalence of anal sex; high risk of sexual and gender based violence; higher risk of unwanted pregnancies and

unsafe abortions. All these require programming and response by policies and guidelines.

d) Violence and harassment

LGBIs face physical harassment by members of public who mock and assault them for practicing “unnatural” sexual relations. In cases of assault by mob justice, the police often fail to come to their rescue. Upon arrest, police subject them to unnecessary body and house searches allegedly looking for evidence that could link them to other crimes. They are profiled as drug users, past prison convicts or individuals with track records of crimes. They often face arbitrary arrest, are often detained at the police stations, subjected to torture and unnecessary harassment by the police who extort money from them and are only released after bribing their way out. They also suffer sexual abuse from the arresting officers.

e) LGBIs lack proper information and knowledge on how to protect themselves from HIV and other STIs.

f) Intolerance and homophobic responses to LGBIs affect their socio-economic potential

When their identities are discovered, LGBIs cannot seek employment or undertake other forms of business -for example running a kiosk. Sometimes, they have to keep relocating to different residential areas to hide their identity. They are perpetually on the run! Further they are often evicted from their rental houses by neighbours and condemned for their orientation which is termed evil. In cases where they are not evicted from their houses, they are not allowed to use common utilities in the residential compounds such as swimming pools.

LGBIs are also unable to access spiritual nourishment from the society because they are labelled as evil and the teachings in places of worship interpret LGBTI activities as unnatural and unacceptable.

g) Unaffordable SRH services

The SRH commodities required by LGBIs were said to be costly and hence out of their reach. For instance, condoms, lubricants or screening and treatment for STIs were said to be very costly. During the Embu hearing, one witness noted how expensive female condoms

are compared to male condoms.

h) Cultural norms and practices

Societal and family pressure for homosexuals to marry and start a family, like the majority members of the society, was reported to have resulted in them being bi-sexual since they marry to please family members and to be accepted by society. Nevertheless, they continue to keep same sex partners and engage in both homosexual and heterosexual relationships - behaviours that increase their risks of STI/HIV and AIDS infections.

There were also reports that many communities deny that such groups exist in their midst. Particularly, the Luo Council of Elders in Kisumu was categorical that there were no such groups in Kisumu despite the increasing number of LGBTIs associations in this region seeking to promote the rights of sexual minorities. The implication of this has been that their needs, especially sexual and reproductive health, are not catered for.

Disapproval by society of their sexual relationships, often coupled with hostility and violence targeted at them, was said to have forced these groups to hide their sexual relationships and activities from friends and families.

It emerged that the young and adolescents who are still under their parents' care are afraid to disclose their sexual orientation for fear of being considered as having mental disabilities and subjected to counselling, condemnation and being reprimanded.

6.2.2 Transgender

a) Stigma and Discrimination

The Inquiry heard that transgender people in Kenya suffer stigma and discrimination and are not able to access gender re-assignment therapy. A witness who testified at the Inquiry indicated that she had undergone all the processes of re-assignment but Kenyatta National Hospital declined the surgery and did not offer any reasons for declining. Her attempts to appeal to the Kenya Medical Practitioners and Dentist's Board have not been successful. Without being allowed to complete the therapy, transgender people suffer identity problems since they are biologically either male or female, yet

they present themselves in one of the gender by mode of dressing, personality expressions or through other socially defined roles. When arrested, police often face difficulties regarding what cells (male or female) to detain transgender individuals. When at entertainment areas, they are afraid of using bathrooms designated for either sex for fear of being caught by other people and accused or mistaken to be using bathrooms for sexual crimes. The witness testified that sometimes they meet opposite sex partners who demand to have sexual relationships with them. When they discover that they are not female or male (depending on the gender of the sex partner), they scream and attract members of public to the hotel room causing public nuisance, stigma and embarrassment to the transgender person.

A transgender witness further narrated how she had faced different forms of discrimination from friends, colleagues and the law. For instance, she had been denied the right to change the gender in her identity card, passport and the name on her academic certificates. Given the socialisation process in most communities, there is a general denial of the existence of people who are not hetero-normative.

The transgendered noted that they are discriminated in the health facilities where they are required to indicate their gender; in addition, it has not been possible to get sex change surgery and the medical treatment that goes with it.

b) Unaffordable SRH services

The Inquiry was also informed that medical treatment for the transgender persons is very expensive. Although gender identity disorder, or gender dysphoria, is recognised as a mental disorder, hormonal therapy has not been subsidised and can cost around KSHs. 2,000 per month for a transgender woman who has undergone castration, and much more for a transgender woman who has not. In addition, hormone testing machines are not available in public hospitals, so patients must go to private facilities, which charge between KSHs. 5,000 and KSHs. 6,000. These costs are out of the reach of the transgender people as generally a highly marginalised and impoverished group.¹¹⁸

¹¹⁸ Transgender Education 2011, Evidence to the Experts' Forum, Nairobi, 25 August 2011

6.2.3 Sex Workers

Sex workers (women and men) have lived on the margins of society through most of human history. Stereotypes, derogatory names, stigma and general indifference to their humanity prevail worldwide. While the exchange of sex for money is a common practice around the world, sex workers are often treated as less than human- both in cultural norms and public policy.¹¹⁹

Testimonies received from sex workers indicated that they suffer a lot of difficulties and violations in the course of their work. These include the following:

- Violence from their clients who demand for sex and sometimes decline to pay;
- Rape and harassment by law enforcement agents;
- Arrests by police officers who extort money from them;
- Stigma and discrimination of both the sex workers and their children by the society;
- Exposure to HIV transmission when their clients refuse to use condoms or engage in rough sex that tears the condom during the intercourse;
- Exploitation by male clients who pay very little for the services;
- Stigma and discrimination as they are labelled as “sinners” or evil people who should not access spiritual services in places of worship.

6.3 International Human Rights Framework

The Universal Declaration on Human Rights states that “all human beings are born free and equal in dignity and rights.”¹²⁰ All human rights are universal, interdependent, indivisible and interrelated and sexual orientation and gender identity are integral to everyone’s dignity and humanity and must not be the basis for discrimination. Sexual minorities are entitled to enjoy all the guaranteed human rights including sexual and reproductive health rights.

Gender identity is understood to refer to each person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth including the personal

¹¹⁹ See write up Sex Workers Project available at <http://www.seworkersproject.org/media-toolkit/resources-for-journalists/> accessed on 25th October 2011.

¹²⁰ Article 1 of the Universal Declaration of human Rights available at <http://www.un.org/en/documents/udhr/> accessed on 17th October 2011.

sense of body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.¹²¹

The preambles of the UDHR, ICCPR and ICESCR recognise the inherent dignity and equal inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world. All these treaties have lists of grounds upon which discrimination is prohibited that include race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.¹²² Sexual minorities claim, and rightly so, that all the rights provided in ICCPR, like the right to Life (Article 6), freedom from inhuman and degrading treatment (Article 7), freedom from slavery, servitude and forced labour (Article 8), freedom of movement and to choose one's residence (Article 12), right to recognition as a person under the law (Article 16), freedom of association (Article 22), right to marry and found a family (Article 23), equality before the law(Article 26) and rights of minorities (Article 27), also apply to them.

The UDHR, ICCPR and ICESCR also provide economic, social and cultural rights that include the right to work (Article 6), the right to social security (Article 9), the right to motherhood, right to marriage and the family, the right to adequate food, clothing, housing and standards of living and freedom from hunger (Article 11) , the right to physical and mental health (Article 12), right to education including a plan for implementing compulsory education free of charge (Article 14) and the rights relating to science and culture (Article 15). These rights are also promoted in other treaties for example CEDAW, Convention against Torture (CAT), the Convention on the Rights of the Child (CRC), and the Convention on Elimination of all Forms of Racial Discrimination, the Convention on Persons with Disabilities among others.

121 The Yogyakarta Principles, Principles of application of International Human Rights law in relation to Sexual orientation and gender identity available at <http://www.yogykartaprinciples.org/> accessed on 10th October 2011

122 United nations 1948, Universal Declaration of Human Rights, GA Res. 217A(III), U.N. Doc A/810, United Nations 1966a. International Covenant on economic, Social and Cultural Rights. 16 December 1966. Treaty series, Vol. 993. Entered into force 3 rd January 1976; United Nations. 1966b. International Covenant on Civil and political Rights. GA Resolution 2200A(XXI), 16 December 1966. Entered into force on 23rd march 1976 available at <http://www2.ohchr.org/english/law/ccpr.htm> and <http://www2.ohchr.org/english/law/cescr.htm> accessed on 17th October 2011.

There is however no treaty that expressly provides for the rights of sexual minorities. Nonetheless, the Committee of Experts monitoring treaty bodies have interpreted and noted these as evolving rights that can be linked to other treaty provisions. Committees of Experts have inferred rights from treaties that apply to sexual minorities. The United Nations Special Rapporteur on the right to the highest attainable standard of physical and mental health explained in his 2004 report that the legal prohibition of same sex relations in many countries, in coupled with widespread lack of support or protection for sexual minorities against violence and discrimination, impedes the enjoyment of sexual and reproductive health rights by many people with lesbian, gay, bisexual or transgender identities or conduct.¹²³

The implication of the provisions under the aforementioned international human rights treats and bodies are that the right to life, security of person and liberty require states to protect against systemic and life threatening persecutions based on sexual orientation and to prosecute sexual based violence offenders and repeal arbitrary laws that criminalise homosexual behaviour. The right to be free from torture or cruel inhuman and degrading treatment requires states to protect sexual minorities from abusive police practices and hold the police accountable for such practices. The right to privacy is often violated by laws prohibiting private and consensual sexual activities. The law that prohibits same sex private activities is discriminatory and offends the right to equality.

In addition, the right to freedom of thought, conscience, opinion and expression requires states to allow private and public expressions of one's sexual orientation without any harassment. The right to equal protection of the law requires states to afford sexual minorities the same legal protection from hate crimes, in custody cases and in exercising their civil liberties, such as freedom of expression, and freedom from arbitrary restriction. They must also have the right to fair trial.

The right to health calls for protection from legislations and policies that limit their access to health services. Finally the right to education requires states to allow promotion of understanding, tolerance and friendship. They should be allowed access to all institution of learning without any discrimination.

¹²³ Prof .Paul hunt report of February 2004, UN Doc. E/CN.4/2004/49 at para 38 available at http://www.ifhro.org/images/stories/ifhro/documents_UN_special_rapporteur/3_4_12.pdf accessed on 7th November 2011.

Navanethem Pillay, United Nations High Commissioner of Human Rights, once said at the UN General Assembly:

*"Those who are lesbian, gay, or bisexual, those who are transgender, trans-sexual or intersex, are full and equal members of the human family, and are entitled to be treated as such."*¹²⁴

In an effort to promote the rights of sexual minorities, in 2003, Brazil attempted to pass a resolution in the UN Commission on Human Rights (Now the human Rights Council) supporting sexual minority rights. This move suffered objection from the African states and was blocked from ever being voted. It was withdrawn and a new strategy to find consensus was organised in Yogyakarta Indonesia from 6th -9th November 2006. Together 29 experts from all geographic regions and the UN high Commissioner Louse Abour (as she then was) gave support during organisation of the meeting. The former UN High Commissioner (Mary Robinson) also attended the meeting. The experts included 13 UN special rapporteurs on different mandates as well as treaty body members and two sitting judges and legal academics and activists.¹²⁵

The resulting document was the Yogyakarta 29 Principles on sexual minorities. This is an aspirational document with principles that draw from existing human rights frameworks. It interprets the existing international treaties and rephrases the language, making them clear and precise to sexual minorities. Each principle has a statement of international human rights law; its application is given the interpretation to find the state's duty and obligation for sexual minorities.¹²⁶

The 29 principles adopted promote the right of sexual minorities to universal enjoyment of human rights, equality and non-discrimination, recognition before the law, right to life, security of person, privacy, freedom from arbitrary deprivation of liberty, fair trial, treatment with

¹²⁴ United Nations office of the High Commissioner for Human Rights (OHCHR) 2008, Statement by the High Commissioner of human Rights to the UN GA on 18th December 2008 available at <http://>

¹²⁵ This is to acknowledge that the Kenya National Commission on Human Rights was represented at the meeting by former Chairman of the Commission Mr. Maina Kiai and Commissioner Lawrence Mute were among the 29 experts that drafted the Yogyakarta Principles. Commissioner Mute has continued to undertake activities aimed at promoting the rights of the LGBTIs as agreed and documented through the principles.

¹²⁶ See the Yogyakarta Principles: available at <http://www.yogyakartaprinciples.org> accessed on 30th September 2011.

humanity while in detention, freedom from torture and cruel inhuman or degrading treatment, protection from all forms of exploitation, sale and trafficking of human beings, right to work, social security and to other social protection measures, an adequate standard of living, adequate housing, right to education, right to health, protection from medical abuses, the right to freedom of thought, conscience and religion, freedom of movement, seek asylum, right to marry and found a family, right to participate in cultural life, right to promote human rights, the right to effective remedies and redress and accountability.¹²⁷

6.4 National Legal and Policy Framework

6.4.1 Legal Framework

The reality in Kenya is that sexual minorities are discriminated against and face a lot of stigma. Their existence is not acknowledged or recognised by national laws and policies and the society at large. Homosexuality is effectively criminalised by the Penal Code under sections 162 and 165. These provide that any person who has carnal knowledge of any person against the order of nature or permits a male person to have carnal knowledge of him or her against the order of nature is guilty of a felony and is liable to imprisonment for twenty one years and fourteen years respectfully. The attempts to decriminalise homosexuality have in the recent past faced a lot of resistance from government and the citizens of Kenya. However, there are no specific provisions on lesbian relationships. Due to immense threats of prosecutions amongst lesbians, they have continued to operate under cover alongside gay men. The Penal Code also criminalises sex work in Kenya. Section 153 (1) (2) and 154 of the penal code states that living off the proceeds of sex work is illegal in Kenya. The penal code makes it an offence for either male or female person to live on earnings of prostitution. It is also an offence for any person to keep or manage or assist in management of a brothel or to lease a house to be used as a brothel (S. 155& 156 of the penal code).¹²⁸ Trends indicate that this law is to a great extent applied on females and not males - thus adopting a gendered interpretation.

¹²⁷ Ibid for details see the Yogyakarta Principles

¹²⁸ Available at <http://www.kenyalaw.org/kenyalaw/klrapp/frames.php> accessed on 25th October 2011.

There are arguments that the Constitution of Kenya 2010 provides an opportunity for safeguarding the rights of sexual minorities in Kenya. This is owing to the fact that it provides for international law being part of the laws of Kenya (Article 2 (5)) and that international treaties ratified by Kenya will also be part of the laws of Kenya (Article 2(6)). Customary international law is developed through consistent practice of states and becomes binding to all member states. The phrase "without distinction of any kind" is all encompassing and the enumerated list is non-exhaustive, as evidenced by word like "such as". The LGBTIs rights activists have argued that the legally binding treaty documents apply to everyone including sexual minorities.

The rights guaranteed in the Kenyan Constitution 2010, under the Bill of Rights, apply to all people including the LGBTIs. Specifically on the right to marry, the constitution provides:

"Every adult has the right to marry a person of the opposite sex, based on the free consent of the parties."¹²⁹

This effectively means that the Constitution forbids same sex marriages but does not specify same sex relationships as forbidden thus sexual minorities are restricted from formalising their relationships into marriages.

The Constitution accords everyone including gay, lesbian and transgender people the right to life (Article 26), the right to equality and not to be discriminated (Article 27 (4)), the right to human dignity (article 28), the right to privacy (Article 31), freedom and security of person (Article 29), freedom of expression (Article 33), access to information (Article 35) and the freedom of association (Article 36). They further are entitled to freedom of movement (article 39) and they have to enjoy the economic, social and cultural rights that include the right to health including reproductive health, right to housing, food, social security and education among others (Article 43).

6.4.2 Policy Framework

The Kenya National AIDS Strategic Plan 2009/10-2012/13 represents the few positive interventions promoting the sexual and reproductive

¹²⁹ Article 45 (2) of the Constitution of Kenya 2010 available at http://www.kenyalaw.org/kenyalaw/klr_app/frames.php accessed on 5th August 2011.

health rights of LGBTIs in Kenya in the recent past. In order to allow the MSM to access full health care services and participate actively in the mitigation of HIV and AIDS transmissions, the Strategic Plan classified this group, together with injecting /intravenous drug users, as Most-at-Risk Populations (MARPS). In addition, the Strategic Plan considered sex workers as a vulnerable category for purposes of programming for HIV and AIDS.

All the provisions of the National Reproductive Health Policy 2007 apply to sex workers. They are entitled to safe motherhood, maternal health, family planning information and services, HIV and AIDS interventions and treatment among others. However their situation is challenging because of the criminalisation of living of the proceeds of prostitution. Many CSOs have programmes for the sex workers that either strive to engage sex workers into alternative sources of livelihood or seek to increase access to health care for those actively engaged in commercial sex work or both. There is evidence however that some donors are reluctant to support programmes targeting commercial sex workers.

6.5 Conclusions and Recommendations

6.5.1 Conclusions

It is clear from the findings that sexual minorities face numerous sexual and reproductive rights violations on the basis of their sexual orientation and behaviour. These largely stem from laws that criminalise them, societal definition of what is morally acceptable and that which is not, denial of their existence by the society, among other factors. It is notable that under national laws, the activities of sexual minorities are largely illegal. The Penal Code especially criminalises gay relationships and sex work in Kenya. This makes it difficult to safeguard the sexual and reproductive rights of sexual minorities in Kenya.

Noteworthy, the Constitution 2010, under the Bill of Rights, is seen as offering an opportunity towards safeguarding the rights of all Kenyans, including sexual minorities, to sexual reproductive health rights. There are also notable efforts that have been aimed at guaranteeing sexual and reproductive rights of minorities. The Kenya National AIDS Strategic Plan 2009/10-2012/13 represents one of the few positive

interventions promoting the sexual and reproductive health rights of sexual minorities in Kenya. The Strategic Plan seeks to allow the MSM to access full health care services and participate actively in the mitigation of HIV and AIDS transmissions. This, it does by, categorising this group as Most-at-Risk Populations (MARPS). The Strategic Plan also considered sex workers as a vulnerable category for purposes of programming for HIV and AIDS. The national reproductive health policy also seeks to protect the rights of sexual minorities.

Nevertheless, evidence from the Inquiry suggests that the protection of the rights of sexual minorities has largely been left to human rights activists. Even so, the activists pushing for the recognition of these rights do not have as much voice, power and influence owing to fact that the law criminalises the orientations and behaviour of sexual minorities while the society is hostile to them. This means that for the sexual and reproductive rights of sexual minorities to become a reality in Kenya, the laws criminalising their activities and behaviours will have to be repealed. Education aimed at changing societal attitudes and ensuring acceptance of the existence of these groups in society will also be essential. Towards this end, the Inquiry makes a number of recommendations for consideration.

6.5.2 Recommendations

a) Lesbian Gay and Bisexual (LGB)

- The Ministry of Health should deliver to its responsibility to ensure equity in access to SRH services without discrimination (articles 27 and 28 of the Constitution 2010).
- Training institutions and professional societies should update their curricula and regulations to ensure that health professional are conscious of the special needs of these sexual minorities. This will ensure that health care providers understand their unique needs.
- The government should decriminalise same sex relationships with a view to allow them to enjoy human rights as enshrined in the Bill of Rights.
- The government must act to stop the violence meted on lesbians and gays instigated in their homes, workplaces,

schools and communities since it amounts to torture and cruel treatment that is forbidden under international treaties and the Kenya Constitution 2010. (Article 29 (c-f)).

- Adolescents who identify as lesbian, gay, bisexual or transgender need to be protected from mental or physical violence.
- In addition to the acknowledgement of MSM as MARPS, the government must also include lesbians in the category and formulate more LGBTIs' friendly policies to govern the same sex relations with a view to enable them access other services without discrimination-for example health, education, employment and hotel accommodation. The government needs to learn from the experts who drafted the MARPS chapter of the Kenya National AIDS Strategic Plan 2009/10-2012/13 on how to develop similar sexual minorities' conscious policies and legislations.
- Health systems must be reoriented to respond to the sexual and reproductive health needs of sexual minorities living in heterosexual relationships.
- At the community level, there is need to create awareness and increase the dissemination of messages for acceptance of the different gender orientations in society with a view to increase levels of acceptance of LGBTIs and have them accorded same status as other human beings.

b) Transgender

- There is need for the government to provide leadership in understanding reproductive health needs of transgender people and to formulate policies that will allow them access health services, including undergoing the necessary therapy and surgery necessary.
- The government must also put in place measures to eradicate stigma and discrimination against transgender with a view to enhance their access to health care services.
- There is need for legislation to govern transgender transition in Kenya. This should protect the rights of transgendered people

and ensure that they are able to acquire the necessary identification and psychosocial support they need during the transition.

- Upon arrests, transgender male and female must be put in safe setting.

c) Sex Workers

- The government must decriminalise and regulate voluntary sex work for men and women in order to make the practice safe for the sex workers and their clients.
- The Counter-Trafficking law must be implemented fully to eradicate instances of forced sex work.
- The government must address the complaints of sexual gender based violence meted on sex workers in course of their work.
- The government should ensure access to male and female condoms and other forms of sexual reproductive health commodities by sex workers.
- Government, development partners, in collaboration with CSOs, should work to have economic empowerment programmes for sex workers who desire to quit the trade and engage in other forms of employment.



' Sexual Minorities demanding access to SRH services'

Chapter Seven

Sexual and Reproductive Health Rights of Vulnerable and Marginalised Groups

7.1 Introduction

Sexual Reproductive Health services must be made available to all people, men and women, boys and girls, including marginalised and vulnerable groups. However, there is tendency to ignore those marginalised and vulnerable within the community in the provision of services. This chapter discusses the status of SRHRs of selected vulnerable and marginalised groups-adolescents/youth, people with disabilities, people living with HIV and AIDS, refugees, and internally displaced persons (IDPs). The chapter begins by assessing the SRH concerns of these vulnerable and marginalised groups, discusses the international, regional and national frameworks that protect and promote the SRH rights of these groups, and ends with recommendations on how to work towards the realisation of the SRHRs of vulnerable and marginalised groups.

7.2 Sexual and Reproductive Health Concerns of Vulnerable and Marginalised Groups

7.2.1 Adolescents and Youth

The Kenyan National Reproductive Health Policy defines adolescents and youth as persons of ages 10-19 and 10-24 years respectively. These categories are considered vulnerable. The Kenya Constitution 2010 on the other hand defines the youth to include individuals who have attained the age of eighteen years but have not attained the age of thirty five years.

The Inquiry established that adolescents and youth face several reproductive health challenges. These include early pregnancy

which is mostly unwanted, complications of unsafe abortion, and complications of pregnancy and childbirth. Adolescents lack easy access to quality and friendly health care, including STI services, safe abortion services, antenatal care and skilled attendance during delivery, which result in higher rates of maternal and perinatal mortality. Other specific Reproductive Health problems experienced by adolescents are being subjected to harmful cultural practices including female genital mutilation (FGM), early forced marriage, and sexual violence and abuse including coerced sex, incest, defilement and rape, which increase their risk to STIs including HIV. Generally adolescents and youth lack relevant accurate information on sex, sexuality and reproductive health. In some instances they are subjected to sex tourism.

a) Unwanted pregnancies

Evidence from the Inquiry indicates that unwanted pregnancies are a serious problem facing adolescent girls and youth in Kenya today. This has a profound effect on the girls who are sometimes forced to procure unsafe abortions, drop out of school, are married off early against their will, abandoned by their male partners and/or family among others. For instance during the Inquiry, witnesses reported that when young girls get pregnant, the men who impregnate them reject them, their fathers disown them and the mothers who are the only providers of comfort blame them for engaging in reckless behaviour hence straining family relationships. A witness who had to drop out of school in fourth form after getting pregnant narrated her experience. She reported thus:

"I got pregnant while in fourth form and since my father was a Muslim, he wanted me to abort saying that my baby was 'mwana haramu'. He took me through hell and I had to get married to somebody against my wishes. I will never forget the experience I went through."

A witness from Nairobi University told the Inquiry how female students who get pregnant while at the University are expected to vacate their halls of residence and seek alternative accommodation, which is often expensive and insecure.

b) Rape

A female student leader from Nairobi University informed the Inquiry that most female students are victims of date rape in the male halls of residence in various campuses and universities across the country.

c) Unsafe abortions

This was said to be rampant among adolescents and youth, especially in universities and other technical colleges. A female student leader from Nairobi University informed the Inquiry that sometimes, arising from abortions; fetuses are collected from dustbins in universities. She noted that most girls do not seek safe abortion services, including post-abortion care, as they fear being known to have aborted.

d) Sexual abuse and harassment

Many a times, female students have had their private sexual activities recorded and posted in the internet by their jilted boyfriends without their knowledge hence exposing them to ridicule and causing them great humiliation.

In addition, young girls are unsuspectingly lured into sexual activities making them highly vulnerable to rape, STIs, pregnancy, drugs and at times arrest. There have been instances where girls have been murdered in circumstances that are not clear. At times, girls are exposed to various forms of sexual harassment in return for favours such as money, grades, internships or pure blackmail.

It was noted that, the sexual reproductive health challenges facing adolescents and youth in Kenya today are due to lack of sex education and information, poor guidance and counselling services, unavailability of youth friendly sexual reproductive health services such as contraceptives among others. This was demonstrated by a witness account of the untold suffering of both male and female university students. A student leader from Moi University noted that many university students suffer in silence and ignorance of their rights and do not consider family planning as a priority issue. She noted that abortion is a common phenomenon among the female students and that most of them do not come out freely to talk about sexuality.

Data from the KSPA cite lack of adequate health facilities offering Youth-Friendly Services in Kenya despite the fact that global literature has demonstrated how YFS are effective in increasing utilisation of health care services among youth including HIV and AIDS services. In 2010, only 7% of all facilities in Kenya offered YFS. Among facilities with a HIV testing system, only one tenth offer YFS, despite the fact that more than 60 percent of Kenyans are aged below 25 years.

7.2.2 Persons with Disabilities

The Convention on the Rights of Persons with Disabilities identifies persons with disability as those who have long term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Article 1 of the CRPD).¹³⁰ Persons with disabilities include the blind, deaf, or those that have physical impairments, intellectual impairments, or disabilities related to mental health. Disabled persons make up 10% of the world's population.¹³¹

The inquiry determined that persons with disabilities suffer myriad sexual and reproductive health rights violations as outlined below:

i. Discrimination and stigma

It emerged from the Inquiry that persons with disabilities are often discriminated against when it comes to accessing sexual and reproductive health services. A group of five women with physical disabilities complained to the inquiry panel how they were discriminated against while seeking SRH services. They noted thus:

“As disabled women in an African community, we have been branded to be without sexual desires and excluded from entering into any marital relationships. The families where we may plan to get married see us as being unable to perform the duties of a wife in the African culture that expects a woman to take care of the home, family and clan”.

¹³⁰ Convention on the Rights of Persons with Disabilities available at <http://www2.ohchr.org/english/law/disabilities-convention.htm> accessed on 20th October 2011.

¹³¹ See WHO/UNFPA guidance note on promoting sexual and reproductive health for persons with disabilities; 2009 available at http://whqlibdoc.who.int/publications/2009/9789241598682_eng.pdf accessed on 21st October 2011.

A male witness from Mombasa County who is visually impaired narrated how his friends and at times his relatives tease him about whether he is the father of his children. He lamented thus:

"I have a normal wife and four children and my fellow men ask me whether all the children are mine and whether I know how I got them. We are not expected to be sexually active and nobody understands why we should have families."

The Inquiry was also informed about how health workers were generally insensitive to the conditions and needs of PWD. Health workers were reported to be asking PWD embarrassing questions such as: *"who could have put you in this situation?"*

A visually impaired man narrated his experience when he accompanied his wife to an ANC thus:

"It was pity all around, as all attention shifted to me instead of my wife who needed the services". "Mtunze vema" the clinic staff implored my wife "usimlete tena huku!" (Take good care of him; don't drag him to this place again).

Pregnant women with physical disabilities also informed the inquiry that they suffered abuses from the health providers who stigmatised them and showed sympathy with their 'double tragedy' of being disabled and pregnant. Health providers assumed that persons with disabilities are sexually inactive.

ii. Lack of informed consent

People with disabilities complained that health care providers performed medical procedures on them without obtaining their consent. For instance, a female witness with disability narrated how she underwent hysterectomy without her consent, and when she inquired from the surgeon why such a long impact procedure was carried out without her consent, the surgeon stated that PWD should not be allowed to give birth to children because they have no potential to adequately bring up the children. She narrated thus:

"I am about 35 years old. I never grew up like other people and am extremely short. I have a lot of difficulty traveling because it is not easy to jump into a matatu. Matatu operators do not like me because they say I am slow and delay them when they

wait for me to slowly crawl into the seats. But I am happy and I have wanted to have a child like other women. For six months I tried to see a doctor at Makadara (CPGH) without success, and eventually I went and paid him at his private clinic, but he still asked me to go back and see him at the CPGH, where I was diagnosed with fibroids and needed to be admitted for them to be removed. The beds at the ward were too high, and I did not get any assistance from the nurses. I eventually was taken for an operation without explanation of what procedures I was to undergo. Three weeks after, I visited the same doctor in his private clinic and he informed me that my uterus had been removed. When I asked the doctor why this was done without my consent, the doctor seemed surprised as he asked me "Did you really expect to have a baby?"¹³²

Another complained of having been subjected to surgical procedures without prior warning, including being taken through what she considered unnecessary caesarean section.

One woman informed the panel that persistent fear of similar treatment, as experienced in the past from a hospital, discouraged her for nearly 10 years from embarking on another pregnancy. Some claimed that owing to their disability, health care providers forcefully and without their consent executed female sterilisation. Often the relatives colluded with the health workers to carry out sterilisation. Some disabled women said they were subjected to forced abortions by care givers or relatives who are responsible for the pregnancy to avoid embarrassment at home.

At community, family or health facilities levels, persons with disability are excluded from decision making process and are always required to follow instructions without questioning. Family and community members justify this act by arguing that PWDs are vulnerable, delicate and helpless, and need sympathy. The legal system has been unable to offer PWD redress since some of them are highly dependent on 3rd parties to access legal services or relevant information on their behalf.

¹³² [Note: It is possible this woman has the condition of achondroplasia. Although the operation of choice for removal of fibroids is myomectomy (removal of the fibroids while preserving the uterus), occasionally, due to the nature of the fibroids this may not be possible, in which case a hysterectomy is performed. It is prudent to discuss such possibility with the patient before hand, and to obtain her consent]

iii. Difficulties in accessing health facilities due to physical infrastructure

People with physical disabilities often find it difficult to access the health facilities owing to the lack of suitable ramps (metallic ramps are too slippery and dangerous and difficult to use when one is driving themselves using wheel chairs or when using crutches). The distances between service areas within health facilities are also prohibitive, especially in the absence of paved paths. Inside clinics, high examination couches and delivery beds make it difficult to get onto them.

iv. High cost of health services

Access to health services for PWDs is constrained by lack of money to pay for transport, hospital charges, drugs and other medical supplies that may be lacking in health institutions. Several PWDs testifying during the Inquiry reported having been detained in public hospitals for lack of money to settle their treatment bills.

v. Sexual harassment and mistreatment

A number of women with disabilities who testified during the Inquiry complained of sexual harassment by health workers. Others complained of having been slapped by nurses in the labour wards because of not following instruction (which they could not hear).

vi. Difficulties in accessing information

The blind and deaf face serious challenges when it comes to access to information. Yet, health care providers and facilities have not designed methods to facilitate communication with them. It was particularly reported that the modes of communication in most health facilities are not in friendly formats that can be accessed by those who are blind, deaf or have intellectual or cognitive impairments. For instance, health information displayed on the boards of health facilities cannot be read by those who are blind, yet, the government and/or the health providers do not provide health information in Braille formats. Similarly, health facilities have not invested in sign language interpreters - this makes communication between the health providers and the deaf a challenge. Also, it appears that the Ministry of Health does not have any specific sexual and reproductive

health programmes targeting the disabled persons despite these people having special SRH needs.

Generally, PWDs are denied basic facts and information about themselves and how to protect themselves from STI and HIV and AIDS. There are no well-coordinated efforts to reach PWDs with contraceptives or STI/HIV and AIDS prevention and care.

7.2.3 People Living with HIV and AIDS

People living with HIV and Aids, especially women, experience myriad forms of sexual and reproductive rights violations. The following were identified during the Inquiry:

- Gender based violence meted on women who are HIV positive; Men/spouses often blame women for 'moving out, picking the virus and 'bringing' the infection into the home.
- Indiscriminate testing of HIV among pregnant mothers without their consent and inadequate counselling offered after receiving the test results.
- Sexual partners of PLWHA continue to demand to have routine sex with the HIV infected women even at times when they are not ready for sex, exposing women to higher risks of re-infection or general weakness.
- Forced sterilisation of HIV positive women with or without their knowledge. It was revealed that widely there was a belief that women living with HIV should never bear children.
- Denial of the right to information and guidance to help HIV positive women make informed decisions on family planning. Misinforming and coercing women to adopt birth control methods preferred by the provider and not the woman herself based on her HIV status.
- Disclosure of HIV status to 3rd parties without their consent. In some cases this includes discussion of one's status with another health provider without informed consent.
- Stigma and discrimination that leads to ostracisation and abandonment.
- Abusive language used against them at the health facilities either during delivery or while attending both ante-natal and post-natal clinics.
- Denial of the opportunity to engage in safe sex and to find suitable marriage partners.

A representative of Women fighting HIV and AIDS in Kenya (WOFAK) had this to say about reasons why WOFAK started a study on documenting cases of forced sterilisation for HIV positive women.

"We received devastating information about health care providers offering HIV positive women sterilisation as a form of family planning. We have also been told of an American funded organisation in western part of Kenya that is coercing women to accept USD 40 as compensation to agree to undergo sterilisation in order to meet the UNAIDS slogan of Zero number of children born with HIV."

The study by Centre for Reproductive Rights and FIDA (K) documented the following from a respondent in a report titled "At Risk":

*"No one informed me of the intention to screen the blood for HIV. I kept quiet; the doctors came and summoned me while I lay on bed as he discussed my status in medical language without explaining to me my status. They did not tell me about my status but they kept asking me how I was feeling and which part of my body was ailing.....When I was discharged, one doctor took me to a room and I knew he wanted to inform me of the results of the test but told me that I would come for them later as they had taken blood samples without my permission. I felt this was wrong treatment from the hospital."*¹³³

7.2.4 Refugees and Internally Displaced Persons

The refugees and IDPs find themselves away from home and in circumstances that deny them routine access to sexual and reproductive health services, mostly because these services are rarely available in their new settings. Often IDPs and refugee camps are located in remote parts of the country and when located in prime lands, they, IDPs or refugees, are confined in a facility such as stadium or forest and their movement closely monitored and controlled. Most camps have limited sanitation services that restrict women's capacity to maintain hygiene and are also sites that expose women to vulnerabilities to sexual violence.

¹³³ Centre for reproductive Rights and FIDA (K); At the Risk Rights Violations of HIV –Positive Women in Kenyan Health Facilities at page 26.

Evidence from a written memorandum received by the Inquiry from Dadaab refugee camp and testimonies from IDPs revealed that:

1. IDPs and refugees suffer violence including sexual violence while in the camps. The housing conditions in the camps expose women to sexual assaults from men or supervisors of the camp activities such as those issuing food rations and/or other utilities. This puts women at risk of contracting STIs and HIV. Many unwanted pregnancies occur especially among adolescent girls.
2. They also have limited access to health care services, including family planning, maternal health care, among others. This is even worse for PWD living in refugee or IDP camps, as they are exposed to multiple vulnerabilities.

7.3 International Human Rights Framework

7.3.1 Adolescents and the Youth

Sexual and reproductive health rights of adolescents and the youth are guaranteed in various human rights instruments. These include the Convention on the Rights of the Child (CRC) and the Convention on Elimination of all Forms of Discrimination against Women (CEDAW) and any other treaty that protects the right to health including reproductive rights of women.

According to the CRC, adolescents and the youth have a right to health and development (Article 12 of CRC). Children have rights to access information (Article 17 of CRC) which include reproductive health information; the right to privacy and confidentiality (Article 16 of CRC); need to be protected from abuse, neglect and exploitation (CRC article 19, 32-36 & 38). States are further required to adopt special measures to ensure physical, sexual and mental integrity of adolescents especially those with disabilities that are particularly vulnerable to abuse and neglect. Schools play an important role in the life of many adolescents and the right to compulsory primary education is promoted by CRC, ICESCR and CEDAW.

Under these instruments, state parties are obligated to provide adolescents and the youth with reproductive health treatment and information to take full charge of their lives. Those that get pregnant

should have health services available. States are also called upon to take measures to reduce maternal mortality and morbidity arising from early pregnancies and unsafe abortions.¹³⁴ Adolescents have a right to the highest attainable standard of health that must be guaranteed by the State. In General Comment No. 4 of the Committee that monitors CRC issued in 2003, it was noted that state parties had not given sufficient attention to the specific concerns of adolescents as rights holders to promote the right to health and development.¹³⁵ The principle of the best interest of the child is of paramount importance.

7.3.2 Persons with Disabilities

A number of human rights instruments seek to safeguard the sexual and reproductive health rights of people with disabilities. Particularly, human rights conventions prohibit discrimination that is based on various grounds including sex, race, colour and other 'status' that has been interpreted to include health status and disability.¹³⁶ The Convention on the Rights of the Child obligates States to address the needs of children with disabilities (Article 23).

The Committee monitoring economic, social and cultural rights, in general comment 14, stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities. The Committee notes that it is a violation of the obligation to respect the right to health if any group is discriminated in accessing services.

The Convention on persons with disabilities that came into force in May 2008 guarantees SRHR to persons with disabilities. It calls for accessibility, including access to medical facilities and information (Article 9). It requires State Parties to take measures to protect persons with disabilities from violence and abuse (Article 16). Article 22 asserts the equal rights of persons with disabilities to privacy and requires the State to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships,

¹³⁴ See General Recommendation 14

¹³⁵ See General Comment No. 4 of CRC available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G03/427/24/PDF/G0342724.pdf?OpenElement> accessed on 30th October 2011.

¹³⁶ See the General Comment No. 14 of ICESCR A/EC.4/2000/4

including in the areas of family planning, fertility and family life (Article 23). The Convention requires that States ensure equal access to health services for persons with disabilities, with specific mention of SRH and population based public health programmes.

7.3.3 People Living with HIV and AIDS

Most international human rights instruments do not specifically address the reproductive rights of people with HIV. However, the rights are inferred from the general framework of human rights that calls for privacy, confidentiality, non-discrimination and informed consent. Increasingly, HIV status is included as a ground upon which one should not be discriminated. Lately the content of the right to health has been defined to include the availability of the HIV prevention, treatment, care and support for children and adults. The International Covenant on Civil and Political Rights provides for the right to equality before the law and non-discrimination.¹³⁷ The Commission on Human Rights has confirmed the “other status” in non-discrimination provisions in international human rights treaties to include HIV and AIDS.¹³⁸ The Commission further confirmed the other rights to be enjoyed by people living with HIV and AIDS to include the right to marry and find a family (Article 23 of ICCPR), the right to privacy (Article 17 of ICCPR), the right to education (Article 26 of UDHR, 12 of ICESCR, Article 12 of CEDAW), and freedom of expression and information (Article 19 of ICCPR).

The relationship between human rights and HIV and AIDs is profound as HIV begets human rights violations such as discrimination and violence. CEDAW protects the right of women in various aspects that are central in the prevention and management of HIV and AIDS. These include the right to decide freely and responsibly the number and spacing of their children and to have access to information; education and means to enable them exercise these rights.¹³⁹ CEDAW further obliges states parties to address all aspects of gender-based discrimination in law, policy and practice.

The international guidelines on HIV and AIDS and human rights

¹³⁷ See International Covenant on Civil and political Rights, articles 14 and 26, available at <http://www2ohchr.org/english/law/ccpr.htm> accessed on 19th October 2011.

¹³⁸ Commission on Human Rights resolutions 1995/44 of 3rd March 1995 and 1996/43 of 19th April 1996 available at...

¹³⁹ CEDAW G.A.Res.34/180 (1978) Article 16.1 e available at <http://www.2ohchr.org/english/law/cedaw.htm> accessed on 17th October 2011

released by UNAIDS and the Office of the High Commissioner of Human Rights (OHCHR) recognise a rights based approach as an effective response to HIV epidemic. The approach involves establishing appropriate governmental institutional responsibilities to support and promote the rights of the vulnerable groups among women, children and injecting drug users. Under guideline No. 5, states are encouraged to enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, including people living with HIV and AIDS, from discrimination in both public and private sectors to ensure privacy, confidentiality, ethics and research involving human subjects and provide speedy effective administrative civil remedies.¹⁴⁰

For women who qualify to be put on PMTCT, the services must be given without any discrimination. PMTCT programmes bring to the fore certain fundamental human rights including the right to liberty, security of a person, privacy, health, and freedom from discrimination.¹⁴¹ A briefing paper by the Centre for Reproductive Rights on Protecting Human Rights in Programmes to Prevent Mother to Child Transmission of HIV notes that the above rights are violated when women are denied the opportunity to give informed consent to HIV testing and treatment, where the confidentiality is not respected, and where their involvement in PMTCT programmes serves to reinforce discrimination and stigma associated with HIV and AIDS.¹⁴²

7.3.4 Refugees and IDPs

The rights of IDPs and refugees are safeguarded in various international human rights instruments. The 1951 Refugee Convention requires host countries to treat refugees lawfully staying in their territories the same as their nationals are treated with respect to social security schemes, including those covering maternity and sickness (Article 24(1) b). For refugees who do not meet the criterion of “lawful stay” and for non-Convention refugees, UNHCR works to guarantee that

140 Office of the U.N. High Commissioner for Human Rights (OHCHR) and the Joint U.N. Programme on HIV and AIDS (UNAIDS), International Guidelines on HIV AND AIDSS and Human Rights: 2006 Consolidated version, U.N. Doc HR/PUB/06/9, Sales No. E.06.XIV.4 (2006) available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf accessed on 17th October 2011.

141 Office of the U.N. High Commissioner for Human Rights and Joint U.N. Programme on HIV and AIDS (UNAIDS) Human Rights International Guidelines, available at http://www.unaids.org/htm/pub/publications/irc-pub02/jc520-humanrights_en_pdf.htm accessed on 15th October 2011

142 Centre for reproductive Rights Briefing paper on Pregnant Women Living with HIV and AIDS: Protecting Human Rights in Programmes to prevent Mother to Child Transmission of HIV available at <http://reproductiverights.org/en/resources/publications/briefing-papers> accessed on 14th October 2011.

they are treated no worse than foreigners by the state (Article 7(1)). With respect to health, this can often mean little if there is no access to national health services. In the case of sexual and reproductive health care, refugees can be faced with local restrictions on access to certain services, including information.

The right to health provided in the Constitution as well as in international instruments such as ICESCR and CEDAW is a basic right that is applicable to all people including refugees and IDPs. The immediate obligations arising from the right to health and by extension SRH is that it should not be discriminatory.

In the refugee and IDP camps, all the reproductive health facilities are limited to provisions availed by the host government and CSOs working within the communities. The inquiry thus recommends that the government should strengthen its mechanisms for the provision of SRH services for displaced populations living in Kenya.

7.4 National Legal and Policy Framework

7.4.1 Adolescents

The Adolescent Reproductive Health and Development Policy of 2003 recognised that the optimal health of the adolescent population in Kenya will increase productivity. As such, it aimed to address the various challenges facing adolescents in Kenya. Further, the Reproductive Health Policy of 2007 set to improve the reproductive health of adolescents and ensure adolescents and the youth have full access to sexual and reproductive health information. It also sought to have youth friendly reproductive health services and to promote a multi-sectoral approach in addressing adolescents sexual and reproductive health needs and strengthen partnerships with CSOs.

Article 53 of the Constitution of Kenya 2010 protects the rights of adolescent children to health care, protection from abuse and neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour. In all the interventions and matters concerning the child, their best interests are paramount. These rights are also protected in the Children's Act 2001. On the other hand, reproductive rights of adolescents who

are adults are protected under Article 43 of the Constitution- which seeks to ensure that adolescents enjoy the right to health including reproductive health care (Article 43 (1) (a) and other rights that form the underlying determinants of the right to health including right to education, right to be free from hunger, right to social security, to clean and safe water and to accessible adequate housing (Article 43 (1) (b-f).

The Sexual Offences Act (SOA) 2006 protects adolescents from sexual abuses namely incest, defilement and rape.

The Counter Trafficking in Persons Act also seeks to protect adolescents from sexual abuse occasioned by trafficking for sexual exploitation. The law spells out tough penalties for offenders. This may act as deterrent measure to the would-be offenders.

It is therefore notable that Kenya has in place a policy and legal framework to address issues of adolescent access to sexual and reproductive health. The challenge lies in their implementation.

7.4.2 Persons with Disabilities

The Persons with Disabilities Act, No 14 of 2003¹⁴³ prohibits discrimination against persons with disabilities and spells out their entitlements. Under the Act, they are entitled to a barrier free and disability friendly environment to enable them access buildings, roads and other social amenities and assistive devices and other equipment to promote their mobility. The Act further provides for representation of persons with disabilities, through the Council of Persons with Disabilities, in the implementation of the national health programmes under the ministry responsible for health for purposes, among others, of enabling persons with disabilities receive free rehabilitation and medical services in public and private health institutions, availing essential health services to persons with disabilities at affordable cost, availing field medical personnel to local health institutions for the benefit of persons with disabilities and prompt attendance by medical personnel to persons with disabilities (S. 20 d-g). It is however notable that no attempts have been made so far to implement section 20 of the Persons with Disabilities Act of 2003. Further, there

¹⁴³ See the Persons with Disabilities Act of 2003 available at http://www.kenyalaw.org/kenyalaw/klr_app/frames.php accessed on 24th October 2011.

was no mention of the role of the National Council for Persons with Disabilities in programming of reproductive health interventions targeting PWD.

The Constitution 2010 provides for the rights of all people, including persons with disabilities, to life (Article 26), equality and non-discrimination (Article 27(4), human dignity (Article 28) and privacy (Article 31). It also provides for enjoyment of economic, social and cultural rights in Article 43. Specifically, Article 54 provides for the rights of persons with disabilities to be treated with dignity and respect, access education, reasonable access to all public places, to use sign language, Braille and other appropriate means of communication and access to materials and devices to overcome constraints arising from the person's disability.

The National Reproductive Health Policy 2007 does not mention or make provisions for persons with disabilities –yet they are a vulnerable group that should be adequately catered for. Consequently, no attempts have been made to provide affordable health care services, taking into account, the special needs of PWD such as physical accessibility to health facilities, protection of PWD from sexual harassment, abuse and infection of HIV and AIDS, and contraception needs.

7.4.3 People Living with HIV and AIDS

The Sessional Paper No. 4 of 1997 on AIDS in Kenya laid down strategies for prevention and management of HIV and AIDS pandemic. This was followed by the declaration of HIV and AIDS as a national disaster and the establishment of the National Aids Control Council (NACC). The NACC has implemented a multi-sectoral approach that has brought on board various stakeholders. The Council has taken lead in developing numerous policies to deal with HIV and AIDS.

The guidelines and policies relevant to sexual and reproductive health include the Kenya National HIV and AIDS Strategic Plan 2009/10-2012/13, Mainstreaming Gender in HIV Responses in Kenya, The National Action Plan 2009/10-2012/13, Policy on Male Circumcision in Kenya 2008, the National Guidelines for Prevention of Mother to Child HIV and AIDS Transmission 2000, the National Reproductive Health and HIV and AIDS Integration Strategy 2009, and the National Reproductive Health policy 2007.

The 2009 integration policy sought to ensure that HIV and AIDS information and services are offered together with other reproductive health services, and vice versa. It also aimed to ensure availability of capacity at all levels of services provision.

However, in spite of the existence of these policies and guidelines, key challenges persist including the unmet needs for reproductive health services caused by stigma and negative attitudes of service providers, knowledge gaps regarding ARVs and contraceptive methods and inadequate integration of reproductive health and HIV and AIDS services. Further, financing of HIV and AIDS programmes is a challenge due to high costs of drugs, equipment, increasing number of people in need of HIV and AIDS prevention, care and treatment services, and failure by national stakeholders, governments and international community to commit adequate resources to support HIV and AIDS control interventions.

Article 43 (1) (a) of the Constitution, guarantees the right to health including reproductive health and Article 43 (2) states that no one should be denied emergency treatment. Article 27 (4) provides for equality and freedom from discrimination and gives grounds upon which the state should not discriminate directly and indirectly- on the basis of pregnancy and health status.¹⁴⁴

The HIV and AIDS Prevention and Control Act 2006, provides measures for the prevention, management and control of HIV and AIDS and also provides protection and promotion of public health and for the appropriate treatment, counselling, support and care of persons infected or at risk of HIV and AIDS infection. It addresses issues of HIV and AIDS education and information, testing, screening and access to health care services. The law prohibits compulsory testing, providing for voluntary counselling and testing instead. It stresses the need for informed consent. On the other hand, the Public Health Act requires all people infected with STDs to seek treatment. For purposes of controlling the infection, under this Act, HIV and AIDS is a notifiable disease.¹⁴⁵ The Public health Act, in Section 28, makes it an offence to spread infection of any disease wilfully, dangerously

¹⁴⁴ Constitution of Kenya 2010, article 27(4) –The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

¹⁴⁵ Public Health Act Chapter 242 of the laws of Kenya available at http://www.kenyalaw.org/kenyalaw/klr_app/frames.php accessed on 12th October 2011.

and without proper precautions. The Sexual Offences Act¹⁴⁶ and the HIV and AIDS Prevention and Control Act¹⁴⁷ criminalise the deliberate transmission of HIV or any life threatening diseases to other persons within or outside of marriage.

It is to be noted here that the Sexual Offences Act and the HIV and AIDS Prevention and Control Act have not worked well in favour of PLWHA. The criminalisation of deliberate infection as provided in the HIV and AIDS Prevention and Control Act and the Sexual offences Act is very discriminatory to women since they are seen as vectors of HIV rather than persons who have potential to get infected, live with the infection, and as agents useful in mitigating the socio-economic impacts of HIV and AIDS in the society. Since in most cases women are the first to know their status, they will always be victimised for having deliberately infected their sexual partners. These laws target all pregnant women as potential offenders. The laws fail to recognise the socio-cultural and economic difficulties women find themselves in when infected with HIV and AIDS.

7.4.4 Refugees, and IDPs

Currently the IDP policy in Kenya is under development and there is no specific legislation on IDPs. However, the Constitution protects the rights of minorities – including IDPs and refugees - to have reasonable access to especially health – here we include reproductive health services (Article 56(c). Section 16(a) of the Refugees Act provides that refugees shall be entitled to the rights and be subject to the obligations contained in the international conventions to which Kenya is a party; By this provision, the stipulations on sexual and reproductive health that are included in all human rights treaties ratified by Kenya are made applicable to refugees.

7.5 Conclusion and Recommendations

7.5.1 Conclusion

From the findings it is apparent that vulnerable and marginalised groups- adolescents, youth, people with disabilities, people living with HIV/AIDS, IDP and refugees- experience numerous violations

¹⁴⁶ See Act No. 3 of 2006- Sexual offences Act S. 26 available at http://www.kenyalaw.org/kenyalaw/klr_app/frames.php

¹⁴⁷ See Act No. 14 of 2006-HIV and AIDS Prevention and Control Act, S. 26 available at http://www.kenyalaw.org/kenyalaw/klr_app/frames.php

of sexual and reproductive health rights. The violations manifest in discrimination and stigma, harassment and mistreatment, difficulties in accessing the facilities due to physical infrastructure, lack of access to information, lack of involvement in medical decisions affecting them, unaffordability of the health services, among others.

There is ample evidence to suggest that there are various policy, legal, institutional and other frameworks, both national, regional and international, in place to safeguard the SRHRs of the aforementioned groups. Implementation has however been a challenge. Further, an assessment of these policies, legal and institutional frameworks reveals gaps that may perpetuate violation of sexual and reproductive rights of these groups- especially people living with HIV and AIDS- if not addressed.

From the foregoing therefore, the Inquiry recommends a number of interventions to be undertaken by the government and stakeholders with a view to safeguard the sexual and reproductive health rights of vulnerable and marginalised groups in Kenya.

7.5.2 Recommendations

a) Adolescents and Youth

- The government must urgently review and amend Section 38 of the SOA to ensure adequate prosecution of the sexual violence offenders especially when children and adolescents are the complainants.
- The government must promote the right to education for all children including reproductive health education.
- The government must work towards ensuring that youth-friendly, non-discriminatory sexual and reproductive health services—including family planning services—are made widely available and accessible to all adolescents and youth in Kenya.
- The government and other stakeholders must increase the proportion of health facilities offering youth friendly services. These must be comprehensive and integrated. The Ministry of Health needs to ensure that each facility has trained medical personnel in delivery of youth friendly services.

- The government must develop broad based standards and guidelines for implementation of economic, social and cultural rights as provided in Article 43 of the Constitution. Adolescents and youth must be allowed to participate in development of standards and guidelines on reproductive health.

b) Persons with Disabilities

- The government and other stakeholders should seek to enhance access by PWDs to RH services by making facilities friendly through improved physical infrastructure, use communication formats that are accessible by the deaf, blind, and person with other forms of disabilities, and ensure the health equipment such as beds are easily accessible by those with physically disabilities. The provision of integrated SRH services should be under one service areas to reduce unnecessary movements of PWD from one unit to another. This can be facilitated by mainstreaming of health needs of PWD in RH programming, which requires that PWDs are adequately represented in the design, implementation and evaluation of interventions. The training curricula of health professionals should also include health needs and rights of PWD and how to deliver focused care to PWD.
- The government, in partnership with all other stakeholders including human rights organisations and organisations of persons with disabilities, should create and increase awareness on the rights of persons with disabilities including sexual and reproductive health rights.
- The National Council for Persons with Disabilities must work with the government to ensure full implementation of the Disability Act and specifically to promote the right to information on SRH and the right to health as guaranteed in the Convention on the Rights of persons with Disabilities and Section 20 of the Disability Act.
- The government should review the National Reproductive Health Policy 2007 to include priority interventions for persons with disabilities as a vulnerable category in accessing all sexual and reproductive health services including family planning, maternal health and HIV and AIDS services.

- The government must promote more research to determine vulnerabilities of persons with disabilities in accessing and utilising reproductive health services.
- The government must take measures to protect PWD from abusive and coercive practices, such as coercive sterilisation, while seeking sexual and reproductive health services. Clear measures must be put in place to ensure that the right to informed consent for PWD is fully protected.

c) People Living with HIV and AIDS

- The government must enforce the HIV testing policies to ensure guidelines that require health providers to obtain full and informed consent for HIV testing and the obligation to protect the confidentiality of HIV test results are fully adhered to.
- The government and other stakeholders must aim to accelerate universal access to prevention, treatment, care as envisaged in the Abuja call of Accelerated Action towards Universal Access to HIV and AIDS, TB and Malaria Services in Africa 2006.¹⁴⁸
- To improve access, affordability and quality of care, the government must develop a comprehensive social health insurance package for all Kenyans including the PLWHA. Focus must shift from the diseases to the people, considering the vulnerability of PLWHA. There is need to manage stigma associated with HIV as a key strategy of mitigating the spread of HIV and AIDS.
- There is need to promote the sexual and reproductive health rights as provided for in the Constitution of Kenya 2010. This will encourage women to freely come out and voluntarily test for HIV and disclose their status publicly. ARVs should also be made available to those who require them. PMTCT must be provided to all women who require it to prevent vertical mother to child infection during delivery. For universal access to essential health care to be achieved, there must be adequate supply of commodities including essential medicines, ARVs, contraceptives, condoms, vaccines and other drugs.

¹⁴⁸ Special Summit of African Union on HIV and AIDS TB and Malaria 2-5, May 2006 available at <http://www.africa-union.org> accessed on 19th October 2011.

- The offending sections of the sexual offences Act and the HIV Prevention and Control Act that criminalise HIV transmission should be immediately repealed to comply with the Constitution 2010 that prohibits any form of discrimination based on several grounds including health status among others.¹⁴⁹
- The health care professionals should be continuously sensitised on the importance to respect the dignity and rights of people living with HIV and AIDS and especially the vulnerabilities of women.
- All barriers to access to information and services must be removed. This will take collaborative efforts between the Ministry of Health, the National Aids Control Council (NACC), the Kenya National Commission on Human Rights and the National Gender and Equality Commission.
- The government must disseminate correct, reader friendly information on prevention, treatment, care and support on HIV and AIDS, and ensure universal access to male and female condoms for all sexually active persons, especially PLWHA.
- In order to comply with the African Maputo Plan of Action for Implementing the Continental Sexual and Reproductive Health Rights Policy Framework 2007-2010 that was further extended to 2015, the government must re-think its strategy and develop policies and legal frameworks for STIs/HIV and AIDS prevention to support the provision of appropriate and comprehensive HIV and AIDS/STIs care and treatment options for all including pregnant women, mothers, infants, families and PLWHA.¹⁵⁰
- In its prevention work, the government must resource and work towards addressing the gendered aspects surrounding the spread of HIV/AIDs. This implies supporting gender equality and women's empowerment so as to reduce the skewed profiling of women and girls as vectors of HIV infection.

¹⁴⁹ See the Constitution of Kenya article 27(4)

¹⁵⁰ See the Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action) for operationalization of the Continental policy framework for sexual and reproductive Health and Rights 2007-2010 available at http://www.unfpa.org/africa/newdocs/maputo_eng.pdf accessed on 19th October 2011.

d) Refugees and IDPs

- The IDPs camps must be linked to the nearest health care facilities and camp-based outreach health care services made mandatory in all IDP camps to ensure displaced persons continue to access sexual and reproductive health services. IDPs' medical histories need to be recollected and followed when providing health care services in their new settings.
- The refugee camps must be well equipped with functioning health care facilities that offer the whole spectrum of sexual and reproductive health services.



'The Inquiry Panel receiving evidence from a deaf witness in Kisumu'

Chapter Eight

Financing of Sexual and Reproductive Health Care Services

8.1 Introduction

How policy priorities are translated into reality depends on the way the health sector is financed. The Inquiry heard how funding challenges have led to a weak health system thus resulting in inaccessible, unaffordable and poor quality SRH services. In a context where close to half the population lives in poverty,¹⁵¹ even seemingly small charges for services can be prohibitive for individuals and families. As discussed in chapter two, acknowledging that the right to health can only be realised progressively—as resources allow—qualifies the government's obligation to take steps to fulfil this right. Nevertheless, the government must show that the steps it has taken have benefited from 'maximum available resources'.

For this reason, to assess the government's compliance with its obligation to fulfil the rights to SRH, we must consider whether these funding challenges result from genuine resource limitations, or from a failure to allocate available resources in line with human rights principles and standards. This chapter discusses the financial related barriers to SRHR raised during the Inquiry. Specifically, it assesses whether efforts to make SRH services more affordable, including exemptions from user fees, waivers and insurance schemes, have in the past been successful. It then evaluates the resources available to the health sector from various sources, including the government and international donors and considers how equitably and effectively such resources have been spent.

¹⁵¹ See GoK 2010, Draft Progress in Attainment of MDGs and Way Forward towards Achieving MDGs by 2015 in Kenya, p.28.

8.2 The Affordability of Sexual and Reproductive Health Care

According to the government of Kenya, it is 'officially recognised' that the majority of Kenyans, including women, do not have access to affordable health care.¹⁵² The Inquiry heard that user fees are a significant barrier preventing people from accessing SRH services. The government introduced user fees in public health facilities in 1989 as part of a World Bank push for cost-sharing in public services. However, in the context of worsening poverty in the country, the Ministry of Health replaced the cost-sharing policy at level 2 and 3 facilities with the '10/20 policy' in 2004. Under this policy, fees at level 2 and 3 facilities are reduced to a nominal KSHs.10 and KSHs. 20 respectively. In addition, charges for certain services, including reproductive health services, such as ANC (with the exception of the first visit), post-natal care and family planning have been fully exempt from user fees at those levels. Treatment for HIV and AIDS should be free as well.¹⁵³

Despite these policies, the 'burden on poor and indigent households remains high,' observes the Ministries of Health.¹⁵⁴ As women must frequently finance their own reproductive healthcare-a cost that men do not incur. A number of witnesses indicated that they were unable to access family planning, assistance during delivery and care after delivery because they were not able to afford the high costs in health facilities. Cost was an additional barrier facing witnesses with disabilities, living with HIV or AIDs, or who were otherwise economically disadvantaged.

8.3 Detention of Patients Unable to Pay for Services

Government policy also provides that partial or full waivers should be available for non-exempt services when clients cannot pay. However, this system has been criticised as burdensome, demeaning, and dangerous for the health of the client. This is because health care facilities must absorb the costs of both administering the waiver system and providing the services waived, which discourages staff from publicising or granting waivers. The process itself has ten steps and can take a week or more, which is onerous on the facilities and

152 Government of Kenya 2010, Periodic Report to the Committee on the Elimination of all forms of Discrimination Against Women, para. 207

153 MOPHS & MOMS 2009, National Reproductive Health Strategy 2009-2015, p. 62. Exemptions are governed by MOH circulars. See MOH 2002, Guidelines for District Health Management Boards, Hospital Management Boards, and Health Centre Management Committees, p.12

154 MOPHS & MOMS, 2011, Draft National Health Policy Framework 2011-2030, p. 26.

users.¹⁵⁵ Further, users generally have little knowledge about the waiver system and even those aware of waivers do not necessarily understand the eligibility criteria.

The practice where health facilities detain patients when they are discharged, but unable to pay their medical bills—as previously documented in the cases of maternity patients and post-abortion care patients¹⁵⁶—was confirmed during the hearings. A witness during the Nyanza hearing reported a case where a woman was detained after she underwent extensive surgery to repair a ruptured uterus that cost KShs. 24,000. During the Nairobi hearing, the Kenya Network for Grassroots Organisations (KENGO) reported that the practice of detaining patients who are unable to pay hospital bills was widespread in both public and private hospitals.

Noteworthy, this practice is not unique to SRH, but has a bigger impact on women. First, because the gendered nature of poverty means that women are less likely to have money available to pay for reproductive healthcare and are therefore dependant on their partners or families to finance their needs; limiting their decision making capacity. In Nyanza, for example, one witness recounted the story of a married woman detained in hospital. Her mother and father had disagreed about whether it was appropriate for them to pay her hospital bill, or whether this was the responsibility of her husband. Second, because they have a higher level of reproductive healthcare needs.¹⁵⁷

8.4 Health Insurance Schemes

According to the 'Public Expenditure Review', households still make up significant share of total health spending. However, not all household spending will be made directly to health facilities (i.e. 'out of pocket' expenses to pay for services). Some spending is on contributions to health insurance schemes; public and private. It is estimated that over 17% of the total population in Kenya has some form of 'financial risk protection' for health expenses. However, the provision of insurance services has remained limited to urban areas and salaried workers.¹⁵⁸

¹⁵⁵ FIDA-Kenya & CRR, 2007, *Failure to Deliver*. 54.

¹⁵⁶ See FIDA-Kenya & CRR, 2007 *Failure to Deliver*; CRR, 2010, *In Harm's Way*.

¹⁵⁷ CRR 2011, *Submission to the Inquiry*.

¹⁵⁸ MPHS & MOMS 2011, *supra* note 167, at pp. 9, 11.

The public health insurance scheme, the National Hospital Insurance Fund (NHIF), is a parastatal mandated to provide medical insurance cover to all its members and their declared dependants.¹⁵⁹ The Inquiry noted major successes in the growth of the revenue and number of members of the NHIF over the past five years. The total receipts of NHIF for the financial years 2004/05 to 2008/09 showed an upward trend. For example, receipts increased by 11.7% between 2007/08 and 2008/09 and during the same period, the benefits accrued to members rose by 36.9%. The total number of registered NHIF members has been increasing and grew from 1, 650,000 in 2005/06 to 2, 300, 251 in 2008/09, with membership from the informal sector recording a steady growth¹⁶⁰

All Kenyans aged 18 years and above, with a monthly income of more than KShs. 1,000 are obligated to become members of the Fund. However, the high premium for 'voluntary' membership (which is equivalent to a salaried member earning KShs. 7,000 per month) means that the ability of people working in the informal sector to join NHIF is extremely low. During the Experts' Forum, Pumwani Maternity Hospital noted that currently, only 27% of its inpatients are covered by NHIF. To sustain the hospital, it needs to get to 50-70%.¹⁶¹

Further, the capacity of NHIF to effectively off-set out of pocket health expenses is limited, as its rebates mainly cover inpatient services. While new rates were gazetted in July 2010 to cover outpatient treatment (including family planning, antenatal care and treatment for STDs), these outpatient rebates have reportedly not been fully implemented. For these reasons, NHIF was not a popular source of financing among the witnesses that appeared before the hearings and was hardly referred to. Most people do not use or understand how NHIF works. At the Experts' Forum, the Christian Health Association of Kenya (CHAK) commented that 'NHIF totally needs to change its strategy'.¹⁶²

¹⁵⁹ Hospitals are gazetted under the Act, for which NHIF members can benefit from:

- full and comprehensive cover for maternity and medical diseases including surgery at Category A (government) hospitals;
- full and comprehensive cover in Category B (private and mission) hospitals, but where surgery is required, the member may be required to co-pay; and
- specific daily benefits in Category C (private) hospitals.

¹⁶⁰ Kenya service provision assessment study 2010

¹⁶¹ Pumwani Maternity Hospital, Evidence to the Experts' Forum, Nairobi, 24 August 2011 (Dr Barasa).

¹⁶² CHAK 2011, Evidence to Experts Forum, Nairobi, 23 August 2011 (Goodwin Mugo)

Further, the submission by Aga Khan University Hospital argued that the policies of many private health insurance providers in Kenya discriminate against women and children because of the services that they exclude, such as:

- Unpredictable conditions arising during pregnancy or at the time of delivery, such as blood clots, severely high blood pressure or seizures (eclampsia) that need intensive care or high dependency care;
- Miscarriages and ectopic pregnancies that can be life-threatening, especially due to loss of blood and infection and may require extensive surgical medical interventions;
- Newborn babies under 90 days old;
- Family planning;
- Fertility evaluation and treatment;
- Screening, vaccines and treatment for reproductive tract cancers; and
- Screening for sexually transmitted infections.

They recommended that health insurance should be comprehensive, covering the most critical complications that arise for mothers and babies, and not just be part of broader health cover.¹⁶³

The Gay and Lesbian Coalition of Kenya (GALCK) also noted issues relating to insurance. First, few health care insurance providers are willing to recognise same-sex partners as dependents, meaning that each member of the couple must take their own individual insurance policy. In addition, transgendered people are unable to obtain policies from private insurance that would provide coverage for gender reassignment therapy.¹⁶⁴

A number of grassroots health financing initiatives that focus on the user, rather than the provider, were also shared with the Inquiry. For example, CHAK is partnering with civil society organisations to set up micro-insurance schemes targeting 15-24 age groups and are building entrepreneurial skills of mothers to start small businesses so that they can subscribe to NHIF.¹⁶⁵ During the experts' hearings, the Ministry of Health representatives admitted that community-based health financing initiatives have not been effectively applied in the

¹⁶³ Aga Khan 2011, Submission to the Inquiry, p. 3.

¹⁶⁴ GALCK 2011, Evidence to Experts' Forum, Nairobi, 24 August 2011 (MaqC Eric Gaitau)

¹⁶⁵ CHAK, Evidence to Experts Forum, *supra* note 175.

country. This is despite the fact that there are relatively strong savings and cooperatives organisations (SACCOs) in Kenya that could provide a backbone for such initiatives.¹⁶⁶

Other forms of financing sexual reproductive health such as the Output Based Approach (OBA) were reported. The Provincial Director of Medical Services, North Eastern, reported that a voucher system has been introduced through the OBA programme of the Ministry of Health, supported by the German Financial Cooperation. While the programme has had some teething problems (e.g. the rates to be reimbursed to the hospitals), it is nevertheless considered a positive development. OBA evaluation study in Kenya showed that it is a viable scheme in accelerating uptake of a mix of maternal, child health and sexual and reproductive health care services among the most vulnerable poor populations.

The Aga Khan University Hospital noted that achieving universal health cover for the population would be a significant step in achieving social justice in terms of allocation, distribution, availability, accessibility and equality in the provision of health care services, including SRH services.¹⁶⁷ The proposed social health insurance bill appears to have the potential to expand the accessibility of health cover to achieve this goal. However, since the debate on whether to transform NHIF to such a scheme is still ongoing, it is difficult to comment on the impact such a scheme would have on SRH.

8.5 Adequacy of Funding for the Health Sector

According to the Public Expenditure Review 2010, a total of USD 30 (approximately KShs. 2,900) is spent per capita in the health sector in Kenya. This is close to the estimated cost of delivering the NHSSP II estimated at USD 35 annually and the WHO estimated that USD 34 should be spent per capita to achieve the health-related MDGs.¹⁶⁸ However, the health ministries' most recent annual operational plan (AOP6) calculated a funding gap of approximately KSh 30.7 billion.¹⁶⁹ The Inquiry gathered information alluding to the impact of this funding gap on health facilities. As PATH-Kenya told the Experts' Forum, 'we are making policies, but not making a corresponding

¹⁶⁶ MOPHS & MOMS 2011, *supra* note 167, at p. 11.

¹⁶⁷ Aga Khan 2011, Submission to the Inquiry, *supra* note 176, at p. 2.

¹⁶⁸ GoK 2010, Public Expenditure Review, p. 81.

¹⁶⁹ MOPHS & MOMS 2010, Annual Operational Plan 6 July 2010 – July 2011, p.131.

investment in their implementation'.¹⁷⁰

Apart from increasing the costs that patients must bear, underfunding leads to lack of drugs, medical equipment and other commodities, which limit the delivery of quality services. For example, the Medical Superintendent at Wajir District Hospital reported that the government had reduced the hospital's budgetary allocation by three quarters, which had severely hampered services delivery at the facility.¹⁷¹ As a result of underfunding on health infrastructure, new construction has not kept pace with the population increase. In large areas of the country, particularly arid and semi-arid lands, the distance to the nearest health facility with the capacity to carry out life saving interventions is extremely great.¹⁷² The Provincial Director of Medical Services in North Eastern informed the Inquiry that in the entire region, which accounts for a quarter of the country in terms of land mass, only five hospitals are able to provide basic emergency obstetric care. Witnesses reported that while CDF had contributed to the construction of buildings such as maternity wards, lack of adequate funding meant that these facilities were ill equipped and were manned by inadequate staff.

In order to assess the funding of sexual and reproductive health services in the context of funding of the health sector in Kenya, the section that follows evaluates three main sources of funding for the health sector: allocations from government; contributions from donors; and user fees. The general trend in health sector spending shows a stagnating contribution from the government, a decreasing funding from out-of-pocket payments from users, and an increase in donor contributions.¹⁷³ Specifically, the section considers how to interpret these trends, from the point of view of the government's obligation to dedicate maximum available resources to improving SRH.

170 PATH-Kenya 2011, Evidence to Experts' Forum, Nairobi, 25 August 2011 (Rosemarie Muganda-Onyando)

171 Wajir District Hospital 2011, Interview with Medical Superintendent during pre-hearing field visit.

172 GoK 2010, *supra* note 181, at p. 90.

173 MOPHS & MOMS 2011, *supra* note 167, at p. 26.

8.5.1 Government Allocations

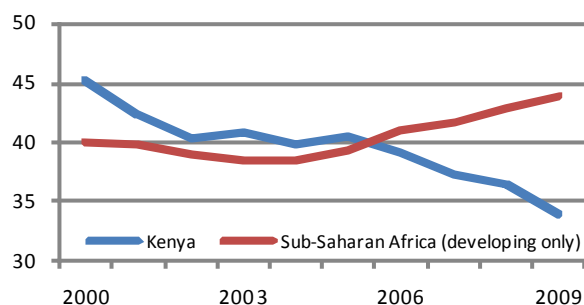


Figure 8.1: Public health expenditure as % of total health expenditure (2000-2009). Source: World Bank Data

Government spending is currently around a third of overall health spending.¹⁷⁴ Over the past decade, the government has remained a major source of funding for the health sector. However, as shown in the figure 8.1, its contribution is decreasing as a percentage of total health spending, unlike other countries in the region. In real terms, the amount of money allocated to the sector has only increased marginally over this time and allocations to Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS) have accounted for around 6% of the government's total budget. This is a drop from approximately 9% at the beginning of the last decade.

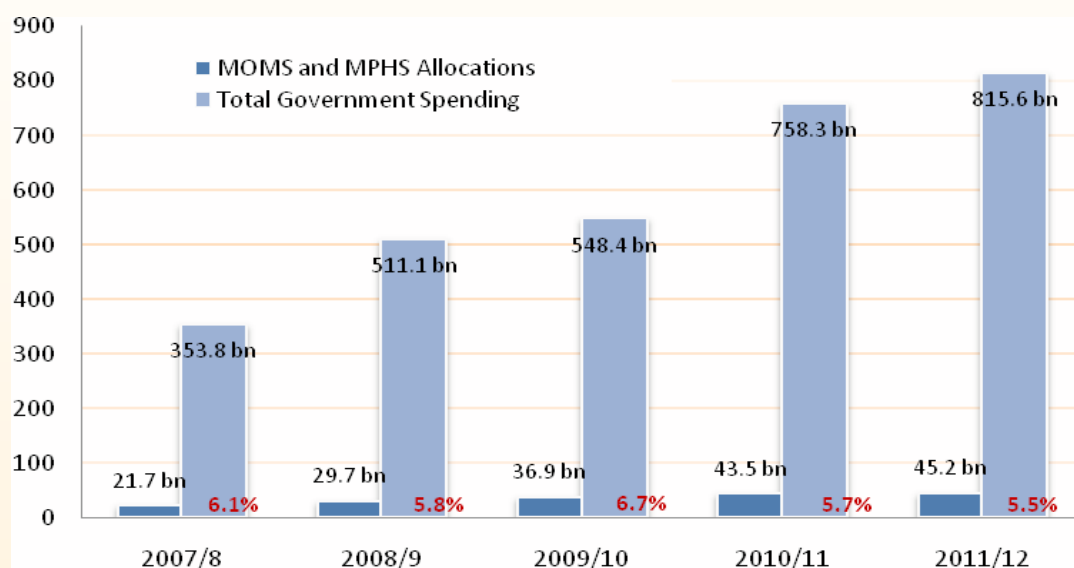


Figure 8.2: Real gross expenditure to the health sector, compared to overall gross expenditure¹⁷⁵

¹⁷⁴ GoK 2011, National Health Accounts 2009/10, p.13

¹⁷⁵ Figures based on gross approved expenditure (2007/8 – 2010/11) and gross estimates (2011/12). Figures indexed to inflation at 2007 CPI.

As seen in the figure 8.2 above, the Government has fallen far short of its commitment to allocate 15% of its budget to health, as pledged in the Abuja Declaration, 2001. In a 2010 scorecard prepared by Africa Public Health Info, Kenya was ranked 24 out of the 54 countries listed by the percentage of the government's budget spent on health. The Public Expenditure Review also shows that while government health spending per capita has grown in recent years, it remains a small percentage of GDP, at 1.7% in 2009.¹⁷⁶ This suggests that the government is not progressively investing in the health sector to achieve the full realisation of the right to health, including SRH.

Table 8.1: Government health spending per capita and as percentage of GDP, 2002/3 to 2008/9

Indicator	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Government health spending per capita (US\$)	5.80	6.30	9.10	10.50	11.60	13.40
Government health spending as % of GDP	1.31	1.25	1.58	1.51	1.65	1.7

Source: GoK 2010, p. 85

In addition to funding channelled through the ministries of health, there are a number of other sources of public funding for the health sector worth noting. These include contributions from various decentralised funds (e.g. constituency development fund (CDF), the local authorities transfer fund (LATF); and the economic stimulus programme) and from local authorities. The health sector has been a major recipient of CDF funding. LATF funds spent in health sector projects in the 2008/2009 financial year amounted to KShs. 170,578,623 which was 3% of the projects supported by the fund.¹⁷⁷ According to the 2009/10 National Health Accounts, local authorities administered 9% of funding in the health sector.¹⁷⁸ The importance of local authorities in delivering SRH services is of course best highlighted by the fact that the busiest maternity hospital in the country, Pumwani Maternity Hospital in Nairobi, which delivers between 1,700-2000 babies every month, is run by a local authority.

¹⁷⁶ GoK 2010, Public Expenditure Review, *supra* note 181, at p.85.

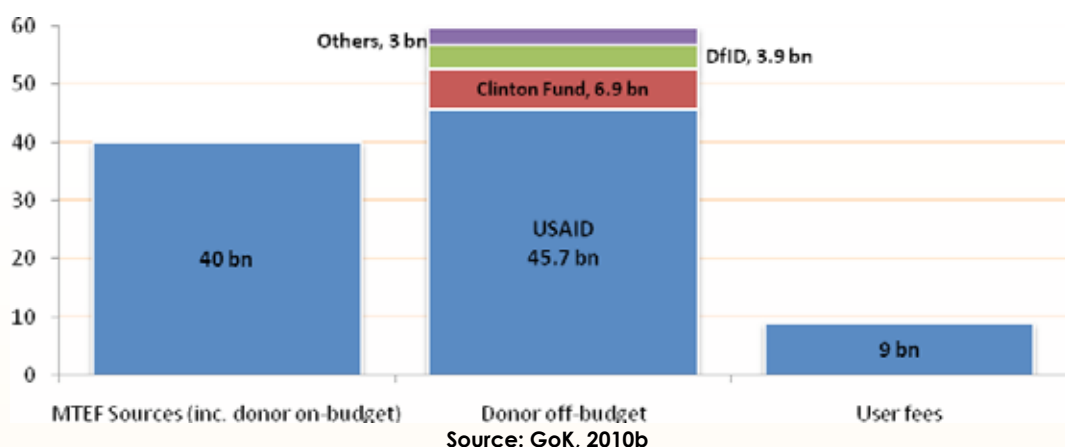
¹⁷⁷ GoK 2009, LATF Annual Report and Revenue of Local Authority Financial Performance FY 2008 – 09

¹⁷⁸ GoK 2011, National Health Accounts 2009/10, p.16

8.5.2 Contributions from Development Partners

A significant amount of health expenditure is not captured in the government's budget. The majority of donor contributions are 'off budget', meaning that they go directly to public, faith-based and non-government health facilities, by-passing the Treasury. As shown in the figure 8.3 out of a total of KSHs. 107.9 billion spent on health in 2009/10, it is estimated that 56% (KSHs. 59.4 billion) was off-budget contributions from development partners.

Figure 8.3: Total on and off-budget spending on health care 2009-10



A number of experts and medical professionals who testified at the hearings reported that they relied heavily on development partners to fund their initiatives. Speaking about initiatives for sex workers, for example, the representative from the Bar Hostess Empowerment and Support Programme noted that 'the government is not taking enough initiative in terms of allocating resources to implement sex workers health programmes, and most of the resources on these programmes were from development partners.'¹⁷⁹ Other initiatives, such as gender recovery centres, are funded by donors because the government only gives a small annual allocation to them. A case in point is the gender recovery centre at the Moi Teaching and Referral Hospital. While the centre's annual budget ranges between KSHs. 6-8 million, the government allocates on average KSHs. 2 million.¹⁸⁰ Professor Miriam Were commented during the Experts' Forum, thus:

¹⁷⁹ Bar Hostess Empowerment and Support Programme 2011, Evidence to Experts' Forum, Nairobi, 24 August 2011 (Peninah Mwangi)

¹⁸⁰ Moi Teaching and Referral Hospital 2011, Interview during pre-hearing field visit.

*In Kenya, we have not adjusted what we want our financial base for the health sector to be. We rely on others to provide everything for us.*¹⁸¹

According to the 2009/10 National Health Accounts, investment from donors has increased from about 16% to 35% in the past 10 years.¹⁸² Apart from governance, health is the second most well funded sector by donors.¹⁸³ This is of course a significant asset for the health sector in Kenya. But such a heavy reliance on donors has other consequences. First, the sustainability of programmes and projects that rely on donor funding is at risk, given the unpredictability of external funding. For example, newspaper reports from late 2011 indicating that the USA might cut KSHs. 65 billion to health sector funding demonstrates the volatility of the current aid environment, particularly in the context of the global financial crisis.¹⁸⁴ Second, it can make it more difficult to prioritise and manage resources needed to implement policies. As the German Development Agency, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), explains in an analysis of the 2010/11 health sector budget, the fact that a significant portion of development funds are not in the budget can be problematic because stakeholders in the health sector are not aware of them and cannot factor them into plans or assess whether they are aligned with the sector's priority areas.¹⁸⁵ At the Experts' Forum, PATH Kenya explained that while donors have put in place a coordination mechanism, called Development Partners in Health- Kenya, intra-donor coordination remains weak and there is a lot of fragmentation in relation to SRH.¹⁸⁶ So, while formally donors are operating within the government's policy framework, a lot of decisions reflect their own priorities in terms of geographic and thematic focus of projects. For example, there continues to be an almost exclusive focus on HIV and AIDS, even within programmes like APHIA PLUS, which are designed, in principle, to provide integrated services at the community level.

181 Professor Miriam Were, Evidence to Experts' Forum, Nairobi, Aug 23, 2011.

182 GoK 2011, National Health Accounts 2009/10, p.13.

183 For the Ministries' of Health AOP6, which runs up to end of 2011, the US government was the biggest contributor. Other major health donors include the African Development Bank, DANIDA (the only one providing budget support) Dfid, the EU, France, GTZ, IFC, the UN system, World Bank, and Italy until this year. Some foundations also work in the country (e.g. Ford). PATH-Kenya 2011, Evidence to Experts' Forum.

184 Gathura, G (2011), 'US might cut Sh65b health aid to Kenya', Daily Nation, 11 September 2011, viewed 28 November 2011, < <http://www.nation.co.ke/News/US+might+cut+Sh65b+health+aid+to+Kenya++/-/1056/1234480/-/729t87z/-/index.html>>.

185 GIZ 2010, Estimated Government Spending 2010/11: Kenyan Health Sector Budget Analysis, p.13.

186 PATH-Kenya 2011, Evidence to the Experts' Forum.

8.5.3 User Fees

Clearly, patients incur a range of user fees for SRH services, which raises serious concerns about equitable access to such services especially among the poorest quintiles of the society. Overall, close to 10% of health funds come from user fees received by hospitals, health centres and dispensaries. This amount, which is estimated to be around KShs. 8 billion, is not reflected in the government's budget.¹⁸⁷ Hospitals still heavily rely on user fees as a source of revenue, especially for recurrent expenses. For example, administrators at Pumwani Maternity Hospital have described user fees as necessary to make up for the shortfall owed by Nairobi City Council.¹⁸⁸ During the Experts' Forum, CHAK noted that roughly 40% of their members' income emanate from user fees. A number of their members also depend on donations, which can make up 30-50% of their income. A few have been able to institute income generating activities. Less than 10% of the funding comes from GoK.¹⁸⁹ So, while reducing out-of-pocket expenses for direct user fees is important for increasing affordability, it is important to find alternative funding mechanisms to address the gap in revenue created. A representative of City Council of Nairobi told the Experts' Forum that:

"The way things are in Kenya, there is no way you can just give health services for free".¹⁹⁰

While the government has taken steps to increase its responsiveness to facilities' resource needs through the recently introduced Health Sector Service Fund (HSSF) and the Hospital Management Service Fund (HMSF), the disbursement of resources from these funds to facilities has just begun, so the impact of these disbursement structures remains to be seen.

8.6 Utilisation of Health Sector Funding

The allocation of the health sector funds to various levels of the health care ultimately affects whether or not the SRH services will be equitably accessible to those who need them. The Benefit incidence analysis shows that the richest 20% of the Kenyan population obtains

187 GoK, 2010, *supra* note 181, at p. 82.

188 FIDA-Kenya & CRR, 2007, *supra* note, at p. 43.

189 CHAK 2011, Evidence to Experts' Forum.

190 Nairobi City Council, Evidence to Experts' Forum, Nairobi 24 August 2011 (Dr. Ayisi)

nearly twice the benefit from government spending on health compared with the poorest 20%. This is because the rich make more use of the more expensive health facilities such as the national referral hospitals. The poor generally make less use of hospitals and so obtain a much lower share of the total subsidies.¹⁹¹

Table 8.2: Percentage distribution of benefit incidence of public spending by facility type

Quintile	National Referral Hospitals	Provincial/District Hospitals	Primary Care Facilities	All Facilities
Poorest	9.5	13.9	20	14.3
Second	9.6	14.1	20.2	14.4
Third	12.8	23.8	22.2	21.3
Fourth	18.8	24.6	21.5	22.9
Richest	49.3	23.5	16	27.1

Source: Public Expenditure Review

The allocation of more funds to higher level facilities providing curative care is reportedly changing in the most recent financial years. When on-and off-budget health expenditures are combined, about 42% of funds is spent on preventative health care, while 29% is spent on curative care and 9% for rural health services. On-budget, government spending is mostly in hospitals (51% in 2008/9 down from 65% of spending in 2002/3), while off-budget expenditures are largely on preventive care. On-budget spending is also predominantly recurrent, with 40% for wages and salaries, while much of the off-budget spending is on commodities, 34%; operations and maintenance 34%; and infrastructure, 15%.¹⁹² Analysis by GIZ also notes that financial allocations during the 2010/11 financial year reflected a shift away from allocating funds to the ministries' development budgets (one-time investments) to their recurrent budgets (ongoing expenses).¹⁹³

Nevertheless, the Ministries of Health acknowledge that equity in resource allocation has not been achieved between regions, across income groups and between curative and preventive services. For example, while resource allocation criteria exist for districts facilities, it is only used for operations and maintenance line items. Comprehensive resource allocation criteria will help avoid duplication of efforts and misuse of resources.¹⁹⁴ The Provincial Director of Medical Services in North Eastern agreed that there is an issue with the criteria the Ministry

¹⁹¹ GoK, 2010, Public Expenditure Review, supra note 181, at p. 95.

¹⁹² GoK 2010, Public Expenditure Review, supra note 181, at p. 82.

¹⁹³ GIZ 2010, supra note 198, at p. 13.

¹⁹⁴ MOPHS & MOMS 2011, supra note 167, at p. 26.

uses to allocate funds to hospitals, so that issues like distance are not given enough weight. For example, a hospital in North Eastern might get a fuel subsidy weighted only slightly higher than a hospital in Central Province, whereas in reality the distances are in fact vastly different.

In terms of the prioritisation of SRH within the health sector, the Reproductive Health Policy notes that the implementation of SRH policies and strategies in Kenya has been affected by disparities in allocations and a lack of specific interventions targeting resources towards the poor and 'hard to reach' populations.¹⁹⁵ The 2009/10 National Health Accounts calculated that per woman of reproductive age, per annum, the reproductive health expenditure was approximately KSHs. 1,009 (USD14). This equates to 13.9% of total health expenditure, as compared to HIV and AIDS services, which make up almost 25% of total health expenditure.¹⁹⁶

In the past four national budgets, the MOPHS has had a specific allocation for 'Family Planning, Maternal and Child Health'. Available figures for this budget line from the government's approved budget estimates suggest that it has decreased from KSHs. 2.3 billion in 2008/9 to KSHs. 1.2 billion in 2010/11. Overall, it amounts to a small fraction of the government's health sector allocation; estimated at about 2%. The allocations to this budget line are divided into three focus areas—with each area divided into sub-activities, each with special allocations. However, according to analysis by Healthy Action (2011), only the allocations for 'materials and special supplies' and 'special machinery and equipment' can be used for securing commodities and providing services. The other activities go to reimbursements, meetings, trainings and other such expenditures. In 2009/2010 there was no allocation to maternal health and only KSHs. 200,000 was allocated for special materials and supplies for child health. Most of the budget allocation is earmarked for family planning.¹⁹⁷

The costing of the National Roadmap for Accelerating the Attainment of the MDGs related to Maternal and Newborn Health in Kenya estimated that an additional KSHs. 2 billion was needed in 2009/10, rising to KSHs. 3 billion in 2010/11 and to KSHs. 4.1 billion in 2011/12, before tapering off over the next decade once investments start to pay off. Similarly, a costing study conducted by USAID concluded that the government would need to spend around USD 8.3 million (approximately KSHs. 802 million) on family planning commodities and direct personnel costs to ensure that all methods of family planning

¹⁹⁵ MOH 2007, National Reproductive Health Policy, at para. 3.1.4.

¹⁹⁶ GoK 2009, Kenya National Health Accounts 2005/6, p. 44.

¹⁹⁷ Healthy Action 2011, Health Budgeting in Kenya—the case of RH/FP, p.30.

were available at government facilities by 2015.¹⁹⁸ A significant issue in health sector financing is that the development budget is very under spent. Typically only 45 % of the budget is actually spent in reality, which means roughly KShs. 3 to 4 billion is not spent each year. An expenditure analysis completed by the Parliamentary Budget Office reports that between 2008/9 and 2010/11:¹⁹⁹

- The average underutilisation of recurrent and development allocations by MOMS was 3.2% and 23.6% respectively;
- The average underutilisation of development allocations by MOPHS was 72.6%.

Bureaucratic bottlenecks that limit the efficient disbursement of allocations, particularly to the lower levels of management was identified as an issue in the NHSSP II. For example, the NHSSP II noted that quarterly financial disbursements are released to districts very late, while statements of expenditure from the districts are returned even later. These delays on both sides have made it difficult to utilise the money for its intended purpose, which in turn has led to serious under-expenditure of approved budgets.²⁰⁰ The Economic Stimulus Programme (ESP) illustrates how this underutilisation impacts on the achievement of outputs in the health sector. The programme, introduced in the 2009/10 budget, provided that in each constituency, the government of Kenya would accomplish the following items presented in table 8.3

198 USAID Health Policy Initiative 2010, *The Cost of Family Planning in Kenya*, p.5. Available at: http://www.healthpolicyinitiative.com/Publications/Documents/1189_1_1189_1_Kenya_Brief_FINAL_7_12_10_acc.pdf

199 Parliamentary Budget Office 2011, *Parliamentary Budget Office 2011, Budget Analysis for Departmental Committee on Health for the Financial Year 2011/12 and Medium Term*, pp. 4, 9.

200 See also, *Healthy Action*, supra note 210, at p.32.

Table 8.3 Economic stimulus programme health sector outputs

Commitment	Budget (KSH)
Construct one (1) maternity, child ward plus admission office	4,000,000,000
Recruit 20 nurses for preventive health care delivery	391,940,000
Purchase five (5) motorcycles for preventive health services	84,000,000
Purchase 20 bicycles for community health workers	12,600,000
Provide Medical Kits for all health facilities	1,000,000,000
Total	5,488,540,000

As of January 2011, none of the 210 health centres had been completed; with only 34 being more than 70% complete.²⁰¹

Lack of coordination between different levels of government has also limited the effectiveness of health sector spending. For example, CDF funds have been used to build new health facilities, and many are not operational because of fragmentation between the decision on infrastructure and the decision on running costs. In 2010, the government reported that up to 1600 dispensaries were constructed without reference to the designs or locations approved by the ministries of health.²⁰² Further, there does not seem to have been coordination between CDF and the Economic Stimulus Programme.

Finally, the Kenya Anti-Corruption Commission (KACC) reports that while public sector allocations for financing health have significantly increased in recent years, corruption stands as 'a key impediment to the impact of well-intentioned spending on health'.²⁰³ The 2006 Global Corruption Report identifies a number of areas in Kenya's health care system that are vulnerable to corruption, including: construction and rehabilitation of health facilities; purchase of equipment and supplies, including drugs; distribution and use of drugs and supplies in service delivery; regulation of quality in products, services, facilities and professionals; medical research; and provision of services by health workers on the ground.²⁰⁴ In addition to the impact on patients, it is generally agreed that corruption accounts for up to 30% of resource wastage, which means the government cannot be said to be utilising

201 GoK 2011, Economic Stimulus Programme Report, Annex 2—Status Report, viewed at: http://www.economicstimulus.go.ke/images/pdf/esp_progress_report_as_at_january2011.pdf

202 GoK 2010, Public Expenditure Review, *supra* note 181, at p. 91.

203 KACC 2011, Health Sector Report, p. 1.

204 KACC 2011, *above*, at p. 2.

its maximum available resources unless it combats corruption.

8.7 Processes of Allocating Finances in the Health Sector

A memorandum submitted to the Inquiry by the Centre for Reproductive Rights noted that the Constitutional protection of the right to information is an essential component to realising the right to health. Realising this right includes ensuring transparent budget allocations in the health sector and explanations about how and why budgetary allocations are made.²⁰⁵ In addition, a key element of a human rights based approach to planning is that concerned groups have the right to participate in the decisions that affect them. However, as it presently stands, the process for determining health sector allocations begins with the Ministry of Finance, which sets three year budget ceilings for each sector in Kenya. In practical terms, this means that the health Ministries determine their budgets based on what the Ministry of Finance has said it will allocate for health expenditures rather than submitting a budget request based on actual needs.²⁰⁶ As a result, 'decisions regarding expenditure allocations to health are influenced largely by decisions and factors outside the sector'.²⁰⁷

At the local level, the HSSF and HMSF set up facility and hospital management committees, which are mandated to approve work plans and budgets of the facility for submission to the national HSSF and HMSF committees. Membership of the committees should include residents in the area of the facility or hospital's jurisdiction, which has the potential to act as an important interface enabling community involvement in the budgetary process at the local level.

At the national level, transparency in budget making is steadily increasing, in particular with the Constitutional requirement of public participation in budget making and with the introduction of parliamentary processes to operationalise this requirement. In their position paper on the implementation of the Constitution, the Ministries of health took note of the provisions in the Bill of Rights that target special groups such as women, youth, children, persons with disabilities, minorities and marginalised groups and highlighted that the template for planning and budgeting must be alive to the

205 CRR 2011, Evidence to the Experts' Forum, Nairobi, 25 August 2011 (Elisa Slattery).

206 Healthy Action 2011, *supra* note 210, at p. 22.

207 MOH 2007, NHSSP II: Midterm Review Report, p.40

particular health related rights and issues of these groups.²⁰⁸ However, it appears too early to judge what the impact of these reforms will be. None of the non-government stakeholders contacted during the Inquiry reported that they were consulted in the process of determining financial allocations to SRH.

8.8 Emerging Issues in Health Financing

With the devolution to counties under the Constitution, the Ministries of Health propose reorganised structures for health service delivery. In this proposed structure, the counties would have responsibility for level 1 – 4 facilities, which will be expected to provide primary care services and referral services such as in-patient medical and surgical care, including reproductive health services. Each county will be expected to develop comprehensive health sector annual operational plans and to develop resource allocation mechanisms to provide access to services by vulnerable populations within the county.²⁰⁹

While discussion on allocations of specific services to either level of government are ongoing and will be clearer sometime in 2012, it seems likely that the majority of SRH services will be run by county governments. It's necessary that the county governments have sufficient resources to provide these services. At the same time, the national government also needs adequate resources to run and manage the national institutions—which it is proposed will include Pumwani Maternity Hospital²¹⁰—that will offer specialised referral SRH services. In this regard, the equalisation fund established under Article 204 of the Constitution will be an important resource for improving SRH services, as its funds can be utilised to provide 'basic services', including health facilities in marginalised areas.

Another constitutional issue raised during the Experts' Forum was the financial implications of implementing Article 43(2) of the Constitution, which provides for the right to emergency medical treatment. CHAK commented that it will be imperative for the government to address the cost implications of this provision, especially for private facilities. Aga Khan University Hospital commented that it would be difficult to issue a generalised policy on the emergency care private hospitals

208 MOPHS & MOMS 2011, Implementation of the Constitution in the Health Sector: draft position paper, pp.13-14.

209 MOPHS & MOMS 2011, above at pp.20-22.

210 MOPHS & MOMS 2011, above at p.36.

are expected to give, as each case should be assessed separately and independently. What is important is that each hospital has a multidisciplinary team which can appraise cases and offer the best solution for each individual case so that the life of the individual is protected at all stages of appraisal.²¹¹

8.9 Conclusion and Recommendations

8.9.1 Conclusion

Although the government has introduced policies designed to limit the costs associated with SRH, these strategies have not been wholly applied in the sector. As a result, sexual and reproductive health services are not affordable to poorer groups in society. Frequently, expense is a compounding factor which, in combination with lack of awareness, distance, dissuades people from seeking SRH services.

Underfunding in the sector has limited the availability of services and compromised the quality of those services that are available. While spending on health overall has increased in the past decade, it is largely because of increased contributions from development partners and not because of higher levels of government investment. The government is still far from meeting its obligation of dedicating 15% of its budget to health, as required under the Abuja Declaration. Government investment in health is important for ensuring sustainability of funding, as well as ensuring that funding provided to the sector meets the key policy areas the government has prioritised. Further, the prioritisation and utilisation of available funding has not been equitable and effective. Lack of transparency has meant that stakeholders in the SRH sector have not had adequate opportunity to articulate their needs in the budgeting process, whilst bureaucratic delays mean that even when funds are available, they are frequently under spent.

Currently, the sector has not had a Health Financing Strategy to guide its resource rationalisation and mobilisation approaches.²¹² Cost information is missing and expenditure review data and recommendations are not applied. The draft Comprehensive National Health Policy Framework 2011-2030 does not address the issue of financial sustainability. It is important that it does so in order to create opportunities for liaising with the Ministry of Finance to

²¹¹ Aga Khan University Hospital 2011, Submission to the Inquiry.

²¹² MPHS & MOMS 2011, *supra* note 167, at p. 12.

address this challenge. For these reasons, the Inquiry concludes that the government has not complied with its obligation to dedicate the maximum of its available resources to progressively realise the right to SRH. To work towards this aim, the Inquiry makes a number of recommendations in the subsequent section.

8.9.1 Recommendations

1. Remove financial barriers that result in the denial of or delays in receiving necessary SRH services:
 - Present to public a list of services that are cost-exempt and ensure they are actually free in practice;
 - Monitor practices in facilities to ensure that informal and inappropriate fees are not being levied;
 - Ensure that women in need of delivery services are not turned away because they cannot pay a fee or deposit;
 - Implement the Ministry of Health's stated commitment to free maternity services in public hospitals by providing the finances and staffing necessary to make it a reality; define explicitly what is included for free in maternity services (the package);
 - Scale up the level of coverage under NHIF and expand the benefits;
 - Systematically promote and scale-up community-based health financing initiatives across the country;
 - Adopt a social health insurance scheme.
2. Implement the waiver system in public health facilities:
 - Develop clear guidelines and procedures for implementing the waiver system. The policy on charging fees for RH services in public facilities needs to be reviewed along with improving efficiency of fee waiver mechanisms in hospitals. It is apparent that neither the 10/20 policy of 2004 nor the scrapping of all maternity fees in levels 2-4 health facilities (2006), have been effectively and systematically implemented, and these charges continue to deny women access to RH services;
 - Present to public the existing components of the waiver system, how it works and is implemented; describe the criteria of inclusion and exclusion;
 - Ensure that determining waiver status does not delay access to care;
 - Reimburse public facilities for administering and granting waivers;

- Develop a policy on the cost implications of the implementation of Article 43(2) of the Constitution that ensure the right to emergency treatment.
3. Increase the amount of resources allocated to the health sector:
 - Increase government allocations to the health sector in order to meet the commitment in the Abuja Declaration. The allocations need to be met before 2015 if Kenya is to achieve most of the MDGs;
 - Document off-budget resources and their composition as part of the budget preparation, sector planning and reporting processes;
 - Finalise and adopt the draft health sector financing strategy.
 4. Ensure that resources allocated to the health sector are spent equitably and effectively:
 - Expand the budget line on family planning and maternal and child health to include other SRH issues. Further, allocate more resources to these budget lines based on evidence on consumption projections of these services, most of which are readily available;
 - Establish a robust, performance-based accounting system to enable timely disbursement of funds, timely production of financial returns for reimbursements, and timely and accurate accounts.
 5. Ensure that the budgetary process is open and transparent and encourages public participation.

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58. UNFPA Ending Widespread Violence Against Women. www.unfpa.org/gender/violence.htm
59. United Nations (UN), Programmes of Action of the international Conference on Population and Development, 1994 <http://www.unfpa.org/icpd/icpd-programme.cfm>
60. United Nations 1948, Universal Declaration of Human Rights, GA Res. 217A (III), U.N. Doc A/810, United Nations 1966a. International Covenant on economic, Social and Cultural Rights. 16 December 1966. Treaty series, Vol, 993. Entered into force 3rd January 1976; United Nations. 1966b. International Covenant on Civil and political Rights. GA Resolution 2200A (XXI), 16 December 1966. Entered into force on 23rd March 1976 <http://www2.ohchr.org/english/law/ccpr.htm> and <http://www2.ohchr.org/english/law/cescr.htm>
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62. WHO (1997) post abortion family planning: a practical guide for programme managers, Geneva, WHO and (1999) Interpreting reproductive health. Geneva, WHO and Safe Abortion: Technical and Policy Guidance for Health Systems <http://www.who.int/reproductive-health>
63. World Health Organization, Preventing Unsafe Abortion (2010) http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/index.html.
64. Write up Sex Workers Project <http://www.seworkersproject.org/media-toolkit/resources-for-journalists/>

Annexes

Annex 1. Complaint Document Presented by FIDA and CRR



To: Kenya National Commission on Human Rights

Re: Public Inquiry on Rights Violations of Women Seeking Reproductive Health Care Services, in Public Facilities and specifically Pumwani Maternity Hospital

Date: June 3, 2009

The Federation of Women Lawyers-Kenya (FIDA Kenya), a national women's rights legal organization, and the Centre for Reproductive Rights (CRR), an international non-governmental organization, hope that the Commission will consider conducting a public inquiry to address rights violations and barriers around reproductive health care services in public health care facilities, and especially Pumwani Maternity Hospital (PMH).

For decades, women seeking reproductive health services in Kenya have been suffering serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay. Shortages of funding, medical staff, and equipment plague the health care system, and dramatically interfere with the ability of health care staff to provide adequate care. These longstanding problems constitute human rights violations in and of themselves, and also have serious public health implications. When women lose trust in the health care system, they are less likely to seek medical care which undermines the government's important efforts to improve maternal health and deal with the AIDS epidemic.

These systemic problems have persisted, in part, because of a dismal lack of accountability within the health care system, which in turn

stems from a lack of basic awareness about patients' rights and the absence of transparent and effective oversight mechanisms. A public inquiry conducted by the Commission would be an important step in restoring faith in the public health system by:

- Raising awareness of these issues
- Demonstrating the magnitude and systemic nature of these problems
- Resulting in concrete recommendations to the Government and specifically to the Ministry of Health, Ministry of Public Health and the Ministry of Local Government,
- Establishing mechanisms for redress and accountability for violations

This letter provides: a summary of the rights violations that women have been and continue to suffer, with a special emphasis on PMH. The information in this letter is based on the desk and field research conducted for the fact-finding reports, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* (2007) and *At Risk: Rights Violations of HIV-Positive Women in Kenyan Health Facilities* (2008), produced by CRR and FIDA Kenya, and ongoing tracking of the state of reproductive health care services in the country.

I. KEY ISSUES

User Fees

User fees create a significant barrier to obtaining quality care. Women have been denied services because they could not pay a deposit fee, resulting in unassisted deliveries and other serious consequences. Although the government has implemented a fee exemption for certain services and a general waiver system in public facilities for those who cannot afford the user fees, these systems have failed to protect women needing reproductive health-care services. The exemption system suffers from inconsistent and ineffective publicity and implementation, so that women and health care providers do not know about the exemption or a facility arbitrarily charges for a service that should be free. In May 2007, then Minister of Health, Hon. Charity Ngilu declared the Ministry of Health's intention to remove maternity fees in public dispensaries and health clinics; it is unclear what the actual effect of this declaration has been. Although government policy provides that contraceptives at government facilities and government-supplied contraceptives at private facilities

must be free-of-charge, women often still pay some kind of fee.

Delays in Care and Detention of Women for Inability to Pay

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

Neglect and mistreatment around Delivery

In some cases, women received little or no care during labour. Women described having to find the delivery ward on their own, and giving birth alone or with the assistance of another patient or an inexperienced trainee or even the hospital guards. Assistance, when it did come, was sometimes accompanied by verbal and physical abuse such as being beaten and slapped during labour and called rude names. Young mothers are particularly vulnerable to discrimination.

Following delivery, women may endure long, uncomfortable waits on a hard, wooden bench before being stitched; unreasonably painful and poorly performed stitching; refusal to provide sufficient anaesthesia—or any anaesthesia at all; and verbal abuse from medical providers during the process.

Supply and Staffing Shortages

Health care providers in Kenya encounter a number of serious challenges to providing quality care. These obstacles include understaffing, lack of institutional support, and inadequate supplies and equipment, which invariably lead to lower-quality services for women and their babies. Health care facilities often lack the most basic supplies, such as anaesthesia, gloves, syringes, surgical blades,

soap and disinfectant, speculums, and bed linens. Patients are often asked to bring their own supplies; when they have not done so, they must beg medical staff to buy the needed item for them at a higher cost or go without it. Shortages of contraceptives and the supplies necessary to insert certain methods also impede women's consistent access to their preferred method of contraception and expose them to the risks of unplanned pregnancy.

Staff shortages result in overworked and overstressed staff with low morale. Understaffing can also lead to inexperienced medical students providing care, including performing surgeries, without adequate supervision. Similarly, non-medical staff sometimes performs the work of nurses, such as assisting with delivery or cutting women during labour. Understaffing and lack of supplies and equipment contribute to unhygienic conditions, which can threaten the lives and health of women and their babies and increase the risk of infection, including HIV. Providers encounter additional structural obstacles to providing quality care in the context of HIV, such as insufficient training about HIV in general and specialized care for HIV-positive women, and the lack of necessary protective equipment and post-exposure prophylaxis to ensure that they can take universal precautions to protect themselves against contracting HIV in the workplace.

Barriers to Care and Rights Violations in the Context of HIV

In the context of HIV, the dangers of a weak health-care system that does not respect patients' rights can be intensified and multiplied. For some women, services such as those necessary for the prevention of mother-to-child transmission (PMTCT) or anti-retroviral treatment are simply not available. In other instances, women are subject to coercive practices and violations of informed consent and confidentiality in testing for HIV during pregnancy or delivery. Women described being turned away from public hospitals and directed to private facilities specializing in HIV care, encountering extensive delays in receiving essential and particularized treatment, and being forced to pay unclear and unexplained costs for services. Health care workers may deny women information on critical treatment options, such as the available methods to reduce peri-natal transmission of the virus. Moreover, women living with HIV often encounter discrimination at the hands of health-care personnel, many of whom hold negative views of HIV-positive women's sexual activity and childbearing. The

post-election violence and dislocation has only exacerbated the difficulties of accessing HIV-related care for many women.

II. THE NEED TO FOCUS SPECIFICALLY ON PUMWANI MATERNITY HOSPITAL

As an area for public inquiry, Pumwani Maternity Hospital (PMH) merits specific attention. PMH is the busiest maternity hospital in East and Central Africa with an average of 80-100 deliveries per day and treats the poorest and youngest women in Kenya. As of 2005, 80% of all the deliveries that occur in Kenyan health facilities take place at PMH. In spite of its central role in providing maternal healthcare in Kenya, women who delivered at PMH described decades of egregious rights violations, including unsafe conditions for delivery and abusive behaviour by PMH staff resulting in infant and maternal mortality, lasting psychological and physical repercussions, and loss of public confidence in PMH and in the health care system. PMH has been swamped with a host of problems, including shortages of staff and beds, long delays for services, lack of supplies and equipment and widespread corruption leading to high levels of maternal and infant mortality. These problems are compounded by the accounts of death, neglect, swapped babies, and missing babies. Currently, the Medical Practitioners and Dentists Board are investigating the case of a baby mutilated during a Caesarean delivery at PMH.

The ongoing, systematic, widespread and deep-rooted corruption at PMH and the local government level, which is responsible for PMH's management, is known to be the leading cause of many of PMH's aforementioned problems.

In response to negative media attention on PMH, there have been several efforts to establish accountability for the problems at PMH by setting up task forces. However, these reports have been largely ineffectual; the findings were not publicized and the recommendations were rarely, if ever, implemented. The most recent PMH task force, in 2004, was set up by the Local Government with a mandate to investigate PMH and to suggest ways and means of solving the widespread problems of the hospital. The PMH task force conducted its investigation of PMH by visiting the hospital, obtaining views from a broad range of people and hearing the experiences of PMH patients. The findings of the task force indicated that there were numerous and grave problems. Among other things, according to Dr. Shadrack Ojwang, who led the PMH Task Force, the task force noted

in its 400-page report that PMH administration was poor; corruption was so rampant that money and supplies were disappearing; there was lack of transparency and, there were widespread complaints of mismanagement and abuse of patients by PMH staff.

The task force's report, however, has not been made public. The Ministry of Health, the Director of Medical Services, the Superintendent of PMH and City Council were the only ones who received copies of the report, according to Dr. Ojwang. Whether or to what extent any of them have engaged with the report is difficult to determine. The efforts of FIDA Kenya to obtain copies of the task force report and to obtain information about PMH's operating procedures and guidelines were unsuccessful. However, according to *The Nation*, the report mentioned that there is evident negligence and laxity among PMH staff in dealing with patients, their babies and their relatives. Despite these alarming findings, the PMH Task Force failed to file legal charges against anyone. When asked why, Dr. Ojwang stated that "it was difficult to pinpoint any one person" responsible for the violations. He further stated that "there were no legal charges brought because we didn't find any serious breach that would require it." Yet, it is clear that the abuse, neglect and mismanagement occurring at PMH constitute serious violations of human rights protected by national, regional and international laws that bind the Kenyan Government.

To date, many of PMH Task Force's recommendations remain unimplemented, and the failure to disclose the Task Force's report undermines the findings and recommendations of the Task Force. This is compounded by the government's failure to provide any public hearings or redress for those who have experienced human rights violations. In spite of the continuous media reports on the matter, no one has been held accountable, nor have adequate efforts to restore quality health care at PMH been made.

Currently, PMH has raised user fees to allegedly make some improvements, placing a heavier burden on PMH's poor and young patients. The removal of maternity fees in public dispensaries and health centres, discussed above does not apply at PMH. In fact, refusal of services to women who cannot afford the fee has been an ongoing problem at PMH, with several women dying while waiting to be admitted because they could not raise the required fee. While there are limited efforts to address PMH's problems, piecemeal and inadequate measures cannot suffice due to the longstanding and

widespread nature of the problem.

- **The large number of women who seek services at PMH.** PMH plays a central role in the provision of maternal health services in Kenya, handling between 25,000-28,000 deliveries per year. A public inquiry by the Commission could be a tremendous step in ensuring maternal and infant health and making safe delivery a reality in Kenya for the many women who seek delivery services at PMH.
- **The ongoing, systematic and longstanding violations.** The government's failure to address the problems has long-lasting and serious repercussions, including influencing women's attitudes about childbearing and seeking reproductive health care. It should be noted that the 2003 Kenya Demographic and Health Survey found that women are shifting away from seeking the services of health care professionals during delivery. Conducting a public inquiry could thus help in rehabilitating PMH's damaged reputation among the Kenyan people and encourage women to seek assisted deliveries.
- **Lack of accountability and redress thus far.** In spite of the public knowledge of PMH's shortcomings, violations continue to occur and victims of past violations have never received redress or remedy for the harms they have suffered. Efforts to solve the problems engulfing PMH by establishing task forces have thus far been unproductive. The intractable nature of the problem calls for the kind of serious attention that a public inquiry by the Commission could bring.

A public inquiry on these issues would be instrumental in bringing an end to the abuses that women in Kenya have been suffering when seeking essential health care services. Thank you for your consideration of our letter. We would be happy to provide any additional information or resources that the Commission might find useful. Please do not hesitate to contact Claris Ogangah Onyango at <claris@fidakenya.org> or Elisa Slattery at <eslattery@reprorights.org>.

Sincerely,

Claris Ogangah Onyango
Senior Legal Counsel
FIDA Kenya

Elisa Slattery
Legal Adviser, Africa Program
Center for Reproductive Rights

Annex 2: Questionnaires used to collect data during the pre-hearings field visits to Health facilities

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS

Public Inquiry into Sexual & Reproductive Health Rights in Kenya

Interview with Health Facilities' Managers (SRH service providers)

Name of Interviewer: _____

Date: _____

Name of Interviewee (optional): _____

Title of Interviewee: _____

Name of Health Facility: _____

Category of health facility (public, private, etc): _____

Specialization of health facility (if any): _____

Introduction and Consent

I work with the Kenya National Commission on Human Rights (KNCHR). We are conducting a national public inquiry into sexual and reproductive health rights and would like to ask you about various relevant issues. We would very much appreciate your participation in this public inquiry. This information will help the KNCHR to advise the government to adequately plan for better sexual and reproductive health services for Kenyans especially those who are most vulnerable. Whatever information you provide will be kept confidential and will not be shared with unauthorized persons nor will it be used for any other purpose except this public inquiry. **Participation in this interview is voluntary and if there is any particular question you may not wish to answer, you have the right not to answer it and I will go on to the next question; you also have the right to terminate the entire interview at any time.** However, we hope that you will participate in and complete this interview since your views will be very important for this inquiry. At this juncture, unless you want to ask me anything about the inquiry I shall begin the interview. (Answer any questions in a manner that will win the confidence of the respondent otherwise proceed to begin the interview if consent is obtained).

2. How many health providers do you have at this facility?

3. Approximately how many clients are served by this health facility?

4. What sexual and reproductive healthcare goods and/or services does this health facility offer? _____
5. Are the goods and/or services listed in Q4 above in stock/available at the moment? (If 'no' why not?) _____
6. Are clients charged a fee for sexual and reproductive healthcare services? If so, how much? _____
7. (If 'yes' to Q6) Are there clients who are unable to pay? How many and what do you do in such situations? _____
8. Is your health facility stocked with all the required facilities, drugs/ medicines, equipment and qualified personnel to offer quality sexual and reproductive healthcare? _____
9. Are there any sexual and reproductive health screening services offered at this health facility? If so, which ones? _____
10. Is this health facility able to deal with emergency sexual and reproductive health issues? If so, which ones? _____
11. Does this health facility have a referral system and how does it work e.g. transfer clients using ambulance services? _____
12. What family planning methods/contraceptives are available at this health facility? _____
13. How often do women die during pregnancy at this health facility? Why? _____
14. How often do women die giving birth at this health facility? Why? _____
15. How often do children die at this health facility before they are (see below) and why?

a) < 1 month old _____

b) < 1 year old _____

c) < 5 years old _____

16. What measures (if any) have been taken by this health facility to eliminate all forms of discrimination in the provision of sexual and reproductive healthcare services in this area? _____

17. appropriate for the local community?

a) Yes (How?) _____

No (Why?) _____

18. do you make to enhance the full realization of sexual and reproductive health rights by all members of this community? ____

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS

Public Inquiry into Sexual & Reproductive Health Rights in Kenya

Interview with Individuals (SRH service seekers)

Name of Interviewer: _____

Date: _____

Name of Interviewee (optional): _____

Introduction and Consent

I work with the Kenya National Commission on Human Rights (KNCHR). We are conducting a national public inquiry into sexual and reproductive health rights and would like to ask you about various relevant issues. We would very much appreciate your participation in this public inquiry. This information will help the KNCHR to advise the government to adequately plan for better sexual and reproductive health services for Kenyans especially those who are most vulnerable. Whatever information you provide will be kept confidential and will not be shared with unauthorized persons nor will it be used for any other purpose except this public inquiry. **Participation in this interview is voluntary and if there is any particular question you may not wish to answer, you have the right not to answer it and I will go on to the next question; you also have the right to terminate the entire interview at any time.** However, we hope that you will participate in and complete this interview since your views will be very important for this inquiry. At this juncture, unless you want to ask me anything about the inquiry I shall begin the interview. (Answer any questions in a manner that will win the confidence of the respondent otherwise proceed to begin the interview if consent is obtained).

Bio Data

Name (optional):

<p>Sex:</p> <p>a) Female</p> <p>b) Male</p> <p>c) Other (specify).....</p>	<p>Religious Affiliation:</p> <p>a) Muslim</p> <p>b) Christian (Catholic)</p> <p>c) Christian (Protestant)</p> <p>d) Traditionalist</p> <p>e) Atheist</p> <p>f) Other (specify)...</p>
<p>Age:</p> <p>a) 15 – 24 years</p> <p>b) 25 – 34 years</p> <p>c) 35 – 44 years</p> <p>d) 45 + years</p> <p>e) Other (specify).....</p>	<p>Cultural Background (Ethnicity):</p> <p>a) Kalenjin</p> <p>b) Kamba</p> <p>c) Kikuyu</p> <p>d) Kisii</p> <p>e) Luhya</p> <p>f) Luo</p> <p>g) Maasai</p> <p>h) Mijikenda</p> <p>i) Somali</p> <p>j) Other (specify).....</p>
<p>Marital status:</p> <p>a) Single</p> <p>b) Married</p> <p>c) Divorced/ Widowed/ Separated</p> <p>d) Other (specify)</p>	<p>Do you have any disability?</p> <p>a) Yes (specify).....</p> <p>b) No</p>
<p>Residence:</p> <p>a) Urban</p> <p>b) Rural</p> <p>c) Sub-Urban</p>	<p>Occupation:</p> <p>a) Child Dependant</p> <p>b) Housewife/husband</p> <p>c) Self-employed</p> <p>d) Employed</p> <p>e) Other (specify).....</p>
<p>Level of education achieved:</p> <p>a) None</p> <p>b) Primary</p> <p>c) Secondary</p> <p>d) College/University</p> <p>e) Other (specify)....</p>	

1. From where do you obtain information on sex and pregnancy/

childbearing and how adequate/reliable do you think it is? _____

2. Do you think most people in this community are able to access correct information on their sexual and reproductive health?

a) Yes _____

b) No _____

3. What challenges do you face in accessing information on safe sex and pregnancy?

4. What are your sexual and reproductive health needs (e.g. family planning)? _____

5. Where do you go to address your sexual and reproductive health needs (family planning, antenatal care, childbirth, postnatal care, treatment for STIs)? Why? _____

6. Do you feel that your needs are satisfied adequately by your provider? _____

7. If 'no' to Q6 above, have you filed a complaint with any authorities? Why/Why not? _____

8. What sexual and reproductive health services are offered by health facilities in this area? And by who? _____

9. Are they appropriate for the groups below and why do you think so?

a) Young people _____

b) Men _____

c) Women _____

d) Persons with disabilities _____

e) Sexual minorities _____

10. Do you use any contraceptives/family planning methods to avoid

unwanted pregnancy or STIs (including HIV AND AIDSS)?

a) Yes (Which? Why?) _____

b) No (Why?) _____

11. Is the contraceptive/family planning method you use readily available whenever you need it? _____
12. What challenges do you and people in this community face in accessing adequate and reliable antenatal, delivery and postnatal healthcare services? _____
13. Are you always able to negotiate and agree before engaging in sex with your sexual partners including making decisions on contraceptive use and the number and spacing of your children?

14. Are you a victim or do you know victims of any social-cultural practices that affect the sexual and reproductive health of members of this community (e.g. FGM, Drug/Substance abuse, Alcohol abuse, Domestic violence, Sexual and/or gender-based violence)?
15. What do you think should be done to ensure more people in this community access better sexual and reproductive healthcare?

Annex 3: International/Regional Treaties Kenya has ratified/acceded or signed

The key international human rights treaties and other instruments that provide for SRHR include:

International Treaties

- Convention on the Elimination of all forms of Discrimination against Women (1979)
- Convention on the Rights of the Child (1989)
- Covenant on Economic, Social and Cultural Rights (1966)
- Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of all forms of Racial Discrimination (1966)
- The Convention Against Torture (1984)
- Convention on Persons with Disabilities

Regional Treaties

- The African Charter on Human and People's Rights (1981)
- The Protocol to the African Charter on Human and People's rights on the Rights of Women in Africa or the "Maputo women protocol" (2003)
- African Charter on the Rights and Welfare of the Child. (1990)

Other Instruments/Commitments

- United Nations World Conference on Human Rights (Vienna 1993)
- Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women.
- Millennium Development Goals (2000)
- The Solemn Declaration on Gender equality in Africa (SDGEA) (2004)

- Abuja Declaration (2001) on HIV and AIDSS, Tuberculosis (TB) and other related Infectious diseases
- The Maputo Plan of Action on Sexual and Reproductive Health and Rights of operationalisation of the Continental Policy framework on Sexual and reproductive Health and Rights (2006)
- The African Health Strategy (2007-2015)
- The African Union Summit on Maternal, Infant and Child Health and Development (2010)
- Campaign on Accelerated reduction of Maternal Mortality in Africa (CARMMA)(2009)

Note. These international and regional treaties and commitments have been interpreted and expanded through General Comments made from time to time by the various treaty monitoring bodies.

Annex 4: List of participants (witnesses) to the public hearings

1) Shaarifa Abubakri	26) Mary Wangeci	51) Jane muthoni
2) Nia Mumba	27) Masha Saidi	52) Rose Akini
3) Doris Gothama	28) Angeline Bhoke	53) Margaret Anyango
4) Bosco Illa	29) Sabina Werem	54) Joyccee Minayo
5) Beatrice Jeremiah	30) Margaret Gati.	55) Francis Ivyo
6) Maren Otieno	31) Rosemary Migiro	56) Pen Kenya
7) Mercy Otieno	32) AderaOsawa	57) Dr. Nduku Kilonzo
8) Lucy Chesi	33) Meshak RiagaOgalo	58) Teresia Njoki
9) Margaret Kitsao	34) Awino Dorothy Juma	59) Dr. Milcah Olando
10) Flora Masamo	35) Inviolata Musiche	60) Dr. Ayisi, Dr. Omondi
11) Hudson Karuma	36) Catherine Imbezi	61) Dr. Barasa
12) Susan Atieno	37) Matthew Khalimi	62) Esther Kiambati
13) Emma Mbura	38) Veronica Shiraku	63) David Otieno
14) Allan Okumu	39) Rose Waringa	64) Rosemarie Muganda
15) Dama Charo	40) Rosemary Anyango	65) Dr. Joseph Wangira
16) Caroline Akinyi	41) Evaline Nafula	66) Dr. Konya W.P
17) Claris Ngánzuku	42) Elizabeth Nafula	67) Maqc Eric Gitau
18) Mwanamizi Chaka	43) Dorcas Wanyama	68) Rechel Kanisa
19) Betty Sharon	44) Geoffrey Kasambeli	69) Elizabeth Aroka
20) Asha Nyakundi	45) Virginia Wanjiku	70) Dubat A. Amey
21) Fredrick Fiche	46) Florence Namalwa	71) Rumana Noor
22) Mary Njeri	47) Noreen Nasimu	72) Amina Diis
23) Stephen Kamau	48) Anne Nalonja	73) Idriss Hassan
24) Carol Muthoni	49) Elizabeth Makokha	74) Suleiman Dagane
25) Anne Nyakio	50) Judith Mahindu	75) Habiba Issack

76) Rukia Ali	101) Vincent Mwachi	128) Moses Ndwiga
77) Yuastur Farah	102) Samuel Ooko	129) Dr. Guyo Jaldesa
78) Marian Osman	103) Joe Okore	130) Dr. Carol Odula
79) Aisha Omar	104) Joan Okoth	131) Halima Hassan
80) Fatuma Abdulllah	105) Sarah Pauline	132) Isha Omar
81) Hawa Nahat	106) Wilbroda Khahoya	133) Abdkadir Gullied
82) Rukia Suguw	107) Evelyne Nafula	134) Zahra Haru
83) Caroline Owino	108) Victoria Kisuya	135) Sofia S. Oman
84) Fatuma Ibrahim	109) Jackline Majuma	136) Fatuma Omar
85) Abdi Abdille	110) George Ofundi	137) Sahare Bare
86) Habiba Hassan	111) Patrick Juma	138) Fatuma Jiran
87) Halima Hassan	112) Bernard Nyongesa	139) Camila Dero
88) Julia Kajuju	113) Khadija Nasimiyu	140) Suado Mohammed
89) Irene Gakii	114) Elizabeth Nafula	141) Amina Abdi
90) Consolata Kadhambi	115) Evaline Hasiro	142) Rukiya Mohammed
91) Joyce Muriuki	116) Cynthia Kibet	143) Mary Wangari
92) Rev Stephen Mugambi	117) Samuel Mwaniki	144) Jeniffer Mureithi
93) Zipporah Muthoni	118) Lawrence Ogalla	145) Hannah Wangari
94) Grace Muthoni	119) Dr. Agnes Nakato	146) John Gicheha
95) Joice Nyamoita Faustine Atamba	120) Michelle Osok	147) Julius Mbugua
96) Pamela Magak George Obuya	121) Ms. Elissa Slattery	148) Jane Wairimu
97) Judith Omangale	122) Dr. Were F.O	149) Maria Njeri
98) David Ogoro	123) Dr. Anthony Mwangi	150) Hadija Mbiti
99) Caroline Achieng Oluoch	124) Alexandria Mahayi	151) Caroline Wambui
100) Hellen Ojiambo	125) Mariam Kamunya	152) Francisca Kakusu
	126) Professor Ngugi	153) James Nganga
	127) Peninah Mwangi	154) Beatrice Mugure

155)	Nancy Gitonga	170)	Janet Chebet	185)	Teresa Oduso
156)	Anne Wacheke	171)	Alice Matere	186)	Asha Ali
157)	John Mbau	172)	Linus Ikale	187)	Dr. Joachim Osur
158)	Sabina Regeria	173)	Omuoyo Samba	188)	Evelyne Opondo
159)	Trizah Akinyi	174)	Metrine Naliaka	189)	Dr. Susan Chebet
160)	Mary Agoa	175)	Josphine Ngaluchi	190)	Prof. Miriam Were
161)	Jackline Achieng	176)	Gladys Anunda	191)	Lithome Asmani Ibrahim
162)	Daniel Ochieng	177)	Alumas Atuchi	192)	Dr. Godwin Muho
163)	Daniel Onyango	178)	Metrine	193)	Dr. Joyce Meme
164)	Naftali Ondigo	179)	Henry Ngugi	194)	Simon Wahome
165)	Fanuel Maramba	180)	Margaret Naeku	195)	Christopher Murray
166)	Aloo Ochieng	181)	Margaret Muthonja	196)	Prof. Joseph Karanja
167)	Moses Masaai	182)	Pamela Munay	197)	Dr. Anne
168)	Dorcas Okisai	183)	Evelyn Nzioki		
169)	Gladys Cheptais	184)	Catherine Nduva		

Note. Some of the witnesses did not wish to have their names published in the report and therefore have been edited out.



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