



KENYA

“I Am Not Dead, But I Am Not Living”

Barriers to Fistula Prevention and Treatment in Kenya

HUMAN
RIGHTS
WATCH



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Summary

[Fistula] is a condition that denied me the chance to enjoy my life as a young person. I was isolated and rejected. All my nights were nights of shedding tears due to genital sores. I carried the condition for 12 years without knowing that I could be treated here in Kenya.... I made several attempts to take my life and was admitted to [a] mental ward.... In May 2007 a successful surgery was done.... The closure of that hole is not all that these women need. After I was operated on, I was returned to the mental ward again. You realize, I am not dead, but I am not living.

—Amolo A., a Kenya woman who had a successful fistula repair and is a community educator on fistula, Nairobi, November 26, 2009

Medically fistula is caused by obstructed labor. But also there is obstructed transport, obstructed family planning, obstructed emergency care, obstructed rights.... Everything is obstructed.

—Dr. Khisa Wakasiaka, a reproductive health expert and fistula surgeon, Nairobi, November 11, 2009

Tens of thousands of women and girls around the world suffer every year from obstetric fistula, a preventable childbirth injury that results in urine and/or stool incontinence. Fistula causes infections, pain, and bad smell, and often triggers stigma and the breakdown of family, work, and community life.

The full global extent of this problem is not known. According to the World Health Organization, fistula strikes roughly 50,000 to 100,000 women and girls every year, mainly in resource poor countries in sub-Saharan Africa and Asia. In Kenya approximately 3,000 women and girls develop fistula every year, while the backlog of those living with untreated fistula is estimated to be between 30,000 and 300,000 cases. There are many doubts about these estimates because few studies have been conducted to establish the extent of this problem in the country. Fistula sufferers are mostly young women and girls with little education. They often come from remote and poor areas where infrastructure is underdeveloped and access to health care, particularly emergency obstetric care, is lacking.

A woman who develops fistula has already gone through the trauma of a long, painful obstructed labor. In most cases, the labor ends with a stillbirth. As the woman begins to

recover from the grief and agony of the failed delivery, she discovers that her body is painfully damaged. She might think that she is suffering from temporary, somewhat normal incontinence. But then she begins to smell, her clothing and bedding are constantly wet, her thighs sting, and she might develop ulcers on her vagina. At first, the woman might try to hide her condition, but usually this is impossible. Sex is painful, and her marriage, as a result, might start to fray or even turn violent. She might be thrown out by her husband, her relatives and friends may think that she is bewitched or cursed. In all likelihood, she will stop working, going to market, and participating in social or religious life. She might live in pain and isolation for years, even decades, before learning that surgery could fix her condition. This news will not be enough for many the fistula survivors who lack the resources and autonomy to pursue surgery. For some, however, surgery provides a chance for a new life.

The Kenyan state violates the rights of fistula sufferers in multiple ways, by denying them their internationally-guaranteed access to the highest attainable standard of health, to health information critical to women's and girls' wellbeing, to their reproductive and maternal health, and to a remedy for the injustices and denial of service that they face. Kenya, as a party to numerous international and regional human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the African Charter on Human and Peoples' Rights (African Charter), is obligated to act to rectify these violations and to eliminate the discrimination that both contributes to the disabling condition of fistula and results from it.

This report is based on field research conducted by Human Rights Watch in November and December 2009 in hospitals in Kisumu, Nairobi, Kisii, and Machakos as well as in Dadaab in March 2010. We interviewed 55 women and girls ranging in age from 14 to 73 years, 53 of whom had fistula. Of the 53 with fistula, twelve were girls aged 14-18 years. We also interviewed nine obstetric fistula surgeons, one anesthetist, three hospital administrators, and nine nurses working in hospital gynecology and labor wards, five of whom worked in fistula wards. We interviewed four secondary and four primary school teachers regarding sexuality education in schools. Further, we talked to nongovernmental organizations working on health and women's rights, government officials, professional associations for doctors and nurses, international donors, United Nations representatives, and an elected councilor representing a ward in Machakos.

Reproductive and maternal health care are considered top development and human rights priorities. The UN Committee on Economic, Social and Cultural rights has identified the

lowering of maternal mortality, and morbidity such as obstetric fistula, as a “major goal” for governments in meeting their human rights obligations. Under the Millennium Development Goals, governments have committed to improve maternal and reproductive health through a 75 per cent reduction in the maternal mortality ratio from 1990 levels, and achieving universal access to reproductive health by 2015.

The Kenya government has taken some positive steps to improve women’s and girls’ reproductive and maternal health. These initiatives include eliminating charges for public family planning services, antenatal and postnatal care, and prevention of mother-to-child HIV transmission. The government has also eliminated charges for delivery in dispensaries and health centers to encourage women to deliver in medical facilities with a skilled birth attendant. In addition, by introducing a system of full or partial fee waiver for access to government hospitals, the government has taken steps to increase access to health care for indigent patients. However, as this report shows through the voices of fistula survivors, many women and girls, particularly the poor, illiterate, and rural, are not fully enjoying the benefit of these policies, and there is urgent need to reevaluate and scale up many of the responses.

The report discusses five areas that require increased attention in order to improve maternal health care and reduce obstetric fistulas: access to family planning information and services, the provision of school-based sexuality education, access to emergency obstetric care including referral and transport systems, overcoming economic barriers to maternal health care services and fistula treatment, and health system accountability.

Women and girls need access to information to make informed choices about their sexual and reproductive lives. They also need information about access to services which help ensure a healthy pregnancy and delivery, and for treating obstetric complications such as fistula. Yet information on reproductive health, family planning, potential complications during pregnancy and childbirth, the advantages of facility deliveries, what fistula is, and the availability and cost of fistula treatment and maternity-related services are all lacking among many of the women and girls we interviewed, and even among some health providers.

For example, 20-year-old Kwamboka W. became pregnant at age 13 while in primary school, developed fistula, and lived with it for seven years before hearing on the radio about a United Nations Population Fund (UNFPA) funded fistula repair camp offering free surgeries. She told us, “I didn’t know anything about family planning or condoms. I just went once and got pregnant. I still have no idea about contraceptives.” Despite some government efforts to introduce sexuality education in upper primary and secondary schools, Kenya has not made

it part of the official syllabus and as a result there is no time allocated within school hours to teach it.

In 2004, the government conducted a fistula needs assessment that showed lack of awareness about fistula in communities as a barrier to its prevention and treatment. Six years later, the government has not taken adequate steps to educate the population, nor to correct the myths that exist about fistula in many communities.

The Kenya government's efforts to ensure affordable maternity care for poor rural women and girls have fallen far short of even its own goals. Upwards of three quarters of the women and girls interviewed by Human Rights Watch described economic constraints as a barrier to accessing maternal health services and fistula repair surgery. Almost all women and girls interviewed for this report told Human Rights Watch how difficult it was to raise the money needed for fistula surgery. To its credit, the government supports donor-funded fistula repair "camps"—consisting of short-term mobilization of women and girls, screening for obstetric fistula, and providing surgery for those affected—in district and provincial hospitals around the country several times a year. These camps offer free repair surgeries, but do not cover all associated costs. In addition, government hospitals offer exemptions and waivers for indigent patients, but these policies have been problematic in practice.

The health user fee waiver policy does not work for several reasons: lack of awareness of the policy among patients and some health providers, some facilities' reluctance to publicize the waivers and deliberate withholding of information when requested by patients, and vague implementation guidelines, including the criteria for determining the financial needs of a patient. Many women and girls living with fistula are poor, but none we spoke to had received a waiver.

Women with obstructed labor, which can lead to fistula, need emergency obstetric care such as Cesarean sections. Inadequate access to emergency obstetric care, especially for poor and rural women, is a longstanding problem in Kenya. Kenyan government statistics have shown that capacity to manage complications during childbirth is weak in many health facilities, including referral facilities such as hospitals. Currently available statistics show that less than 10 percent of all medical facilities in the country are able to offer basic emergency obstetric care, and only 6 percent offer comprehensive emergency obstetric care.

Moreover, health facilities, especially in rural areas, are perpetually understaffed, further limiting timely assistance and referral when women develop obstetric complications. Many

women with obstetric complications develop fistula and experience stillbirth simply because ambulances and fuel are lacking.

In order to correct systemic failures in reducing maternal deaths and obstetric fistula, it is important to get feedback from patients on the quality and acceptability of services provided. But accountability mechanisms, which should serve the purpose of identifying systemic problems in Kenya's health system, are far from effective. There should be accessible ways of providing such feedback, lodging complaints, and ensuring such feedback is acted upon. Real accountability mechanisms would not only enhance trust in the health system but also improve utilization and success of maternal health services.

Most of the women Human Rights Watch interviewed did not know how, or to whom, they could complain about or challenge any of the above barriers. Nor did they have any faith that complaints would result in improved treatment. They were also afraid of retaliation by health staff if they complained. We found no indication that the government had taken any steps to enable illiterate patients to understand their rights and to lodge grievances.

While fistula surgery is increasingly available, the government and organizations providing repair surgeries have paid little attention to the long-term needs of women and girls for physical, emotional, psychological, and economic support after surgery. There are no formal initiatives by the government or other service providers to rehabilitate and reintegrate fistula survivors into families and communities. Fistula survivors have endured social and psychological torment that is unlikely to end with surgery. Women may continue to be stigmatized even after successful repair due to lack of fistula awareness in communities, and unsuccessful repairs can be traumatizing for women. Further, fistula places a heavy financial burden on survivors and their families, and as a result they may need support to become economically productive after repair.

The World Health Organization has developed important recommendations for clinical management of obstetric fistula, as well as program development to address issues of fistula prevention and rehabilitation. However, Kenya has not developed a national strategy to address fistula despite conducting a needs assessment in 2004. The WHO recommends that national strategies to address obstetric fistula be integrated into existing programs on safe motherhood and those to improve maternal and neonatal health generally, but Kenya is not adequately doing this.

Key Recommendations to the Kenyan Government

Develop and implement a national fistula strategy in accordance with the World Health Organization's "Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development." Relevant government ministries, such as the Ministry of Gender and Children Affairs and the two ministries of health, and NGOs should participate in crafting the strategy.

Carry out an awareness-raising campaign to inform the public about the causes of fistula, contributing factors (such as female genital mutilation and early marriage and childbearing), the need for facility deliveries, and the availability of treatment. Involve provincial administrators, religious leaders, and NGOs in the campaign.

Integrate information on fistula into the community strategy by training community health extension workers and community health workers to educate communities about fistula and to identify and refer for treatment women and girls with fistula.

Expand the Community Midwifery Model to cover the whole country and address payment of community midwives.

Urgently improve the financial accessibility of fistula surgery by subsidizing routine repairs in provincial and district hospitals, including follow-up visits, and providing free fistula surgeries for indigent patients.

Urgently improve the quality of and access to emergency obstetric care by:

- increasing the number of health facilities that offer emergency obstetric care;
- developing and implementing guidelines on the management of obstructed labor and the management of women who present with obstetric fistula immediately after birth or who present with an established fistula requiring repair;
- implementing the referral component of the Community Strategy; and
- completing and implementing the referral strategy.

Assess the possibility of an exemption from user fees for all maternal health care, beyond the current exemption for childbirth in dispensaries and health centers.

Methodology

This report is based on interviews conducted in November and December 2009 in Kisii, Machakos, Kisumu, Nairobi and Dadaab in March 2010. Our research included visits to three public hospitals that were holding fistula repair camps, and a mission hospital in Nairobi that does routine fistula operations.¹ We also visited several dispensaries and health centers in Machakos and Kisumu.

Because of the difficulty of finding women and girls living with fistula to interview within their communities, we opted to use the fistula camps at hospitals since they presented the opportunity to interview many women and girls from across regional and ethnic backgrounds in one setting. We received immense cooperation and support from the gynecologists who were organizing the fistula treatment camps, and they were our main gateway to reaching women and girls in the hospitals.

We interviewed 55 women and girls ranging in age from 14 to 73 years old—12 were girls aged 14-18 years—53 of whom had fistula.² Of these, 35 were waiting to undergo fistula repair surgery, 13 had gone through surgery and were recovering in the hospital, and five had come for review following surgery. We also interviewed two women at Machakos General Hospital who were detained for failure to pay hospital charges following complications during pregnancy. Interviews were semi-structured and covered a range of topics related to fistula and maternal health care. We also interviewed nine obstetric fistula surgeons, one anesthetist, three hospital administrators, and nine nurses working in hospital gynecology and labor wards, five of whom worked in fistula wards. Further, we talked to nongovernmental organizations working on health and women's rights, government officials, professional associations for doctors and nurses, international donors, United Nations representatives, and an elected councilor representing a ward in Machakos.

¹ The three public hospitals were level 5 hospitals. Kenya's health care system is organized in six levels. Level 1 is the community level. It consists of using community-owned resource persons and community health and extension workers in health promotion. Level 2 and 3 consist of primary health services, where health promotion and basic treatment services are provided. Only simple diagnostic and short term in-patient services, such as maternity and short recuperative observations are provided at this level. Major treatments are offered in Levels 4 and 5, which comprise sub-district, district and provincial general hospitals. These also serve as referral facilities for Levels 1, 2 and 3. Level 6 are the national referral and teaching hospitals. Ministry of Public Health and Sanitation and Ministry of Medical Services, "Referral Strategy and Investment Plan for Health Services," July 2008-June 2012, p. 25. Machakos and Kisii general hospitals were recently upgraded to level 5 facilities. This report has retained the names Machakos General Hospital and Kisii General Hospital for readability.

² The Convention on the Rights of the Child defines a child as anyone under the age of 18 years. The Kenya Children's Act has a similar definition. Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, art. 1, and the Children's Act, No.8 of 2001, Laws of Kenya, art. 2. We interviewed 12 girls with fistula.

On the subject of sexuality education in schools, Human Rights Watch interviewed four secondary school teachers and four primary school teachers.

Because of the sensitive nature of obstetric fistula, we were mindful not to re-traumatize women and girls we interviewed. Before each interview, we informed interviewees of its purpose, voluntary nature, the kind of issues that would be covered, and the ways in which the data would be used. The interviewees verbally consented to be interviewed. Further verbal consent was given to record the interviews. Women and girls were told that they could decline to answer questions, could take a break, or could end the interview at any time without consequence. We took great care to interview women and girls in a sensitive manner, and ensured that the interview took place in a comfortable and private setting.

We have changed all the names of women and girls interviewed to pseudonyms in order to protect their privacy. The identities of some other interviewees have also been withheld at their request.

Participants did not receive any material compensation from Human Rights Watch. In order to avoid false expectations of financial assistance or support, we made it clear at the start of each interview that we were not able to provide direct individual support to those who spoke with us. When we encountered situations where women and girls were in need of psychological or other medical support, we referred them to local NGOs or others who could assist them.

Interviews were carried out in English and Kiswahili without interpretation and in Kikamba and Dholuo with the assistance of interpreters. All the translators were female health professionals who understood the sensitivity of interviewing fistula survivors.

Human Rights Watch also reviewed research and reports by national and international health and human rights organizations and UN agencies, as well as government policies and statistics on health care in Kenya.

The report also uses material from an obstetric fistula stakeholders meeting organized by the Department of Reproductive Health in the Ministry of Public Health and Sanitation, attended by the Human Rights Watch researcher. The meeting was held on February 4, 2010, and brought together a range of health providers working on obstetric fistula: fistula surgeons and nurses, hospital administrators, government officials, and representatives from the United Nations and non-governmental organizations working on obstetric fistula.

I. Background

Maternal Mortality and Morbidity Globally

Most obstetric complications and deaths are preventable. The causes of maternal deaths and morbidities and the most effective ways of preventing and treating them have been recognized for many years.³ Yet, hundreds of thousands of women and girls die every year as a result of preventable and treatable complications during pregnancy, childbirth, or the six weeks following delivery. Estimates on the number of women who die vary. According to estimates developed by the World Health Organization, UNICEF, UNFPA, and the World Bank, over half a million maternal deaths occur globally each year.⁴ A 2010 analysis of maternal mortality for 181 countries shows an estimated 342,900 maternal deaths occurred in 2008.⁵ Measuring maternal mortality is challenging at best, but the latest available trend data indicate that the global maternal mortality ratio (MMR) declined from 320 per 100,000 live births in 1990 to 251 in 2008.⁶

³ Globally, approximately 80 percent of all maternal deaths are estimated to be caused by direct obstetric causes (hemorrhage; sepsis; hypertension; unsafe abortions; and obstructed labor). Indirect causes include HIV/AIDS, malaria, anemia, and tuberculosis. In countries with high HIV or tuberculosis prevalence, the proportion of indirect causes could be higher. Millennium Project, Task Force on Child Health and Maternal Health, *Who's Got the Power? Transforming Health Systems for Women and Children* (London: Earthscan, 2005), <http://www.unmillenniumproject.org/documents/maternalchild-frontmatter.pdf> (accessed February 2, 2010), p. 80. No single health intervention can by itself significantly reduce maternal deaths. Programs that link services for women from adolescence through pregnancy, delivery, and after delivery are needed. Health experts generally agree that increasing access to family planning, antenatal care, having skilled health workers assisting at birth, and access to emergency obstetric care can greatly reduce maternal deaths and morbidities. See World Health Organization (WHO) et al., *The Millennium Development Goals Report* (New York: United Nations, 2009), www.un.org/millenniumgoals/pdf/MDG%20Report%202009%20ENG.pdf (accessed October 10, 2009), p.27, and Millennium Project, Task Force on Child Health and Maternal Health, *Who's Got the Power?*, pp. 80-89.

⁴ WHO et al., *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank* (Geneva: WHO Press, 2007), www.who.int/whosis/mme_2005.pdf (May 3, 2010), p. 15. New estimates of global maternal mortality are currently being finalized by WHO, UNICEF, UNFPA and the World Bank, and are expected to be released in mid-2010 according to the current Millennium Development Goals Report. See WHO et al., *The Millennium Development Goals Report*, p. 30.

⁵ Margaret C. Hogan et al., "Maternal mortality for 181 countries, 1980–2008: a Systematic Analysis of Progress towards Millennium Development Goal 5," *The Lancet*, April 12, 2010, <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673610605181.pdf?id=e16241398b8e460:73a56a81:128> (accessed April 15, 2010), p. 1.

⁶ *Ibid.*, p. 6. The study notes that the decline reflects progress only in some regions, and very little progress has been made in sub-Saharan Africa, where women face the greatest lifetime risk of dying as a result of pregnancy and childbirth. The study notes wide regional and country variations in maternal mortality ratio decline, adding that only 23 countries are on track to achieve MDG 5 on maternal health, and that the proportion of maternal deaths in sub-Saharan Africa increased vis-à-vis the rest of the world. The maternal mortality ratio is defined as the number of maternal deaths in a population divided by the number of live births. Thus, it depicts the risk of maternal death relative to the number of live births. See also, WHO et al., *The Millennium Development Goals Report*, p.27.

The numbers of women and girls who die do not reveal the full scale of this tragedy. For every woman or girl who dies as a result of pregnancy or childbirth, about 30 more suffer short or long-term injury, infection, or disabilities (maternal morbidities).⁷

The magnitude of global maternal mortality and morbidity and the profile of those most heavily affected reveal chronic and entrenched health inequalities both between and within countries. First, the burden of maternal mortality and morbidity is borne disproportionately by developing countries, mainly those in sub-Saharan Africa.⁸ Second, in many countries, preventable maternal deaths and morbidities more often affect distinct groups of women and girls, such as rural, low-income, ethnic minority, or indigenous women and girls. This is the case even in countries with low maternal mortality ratios. Finally, maternal mortality and morbidity ratios are often indicative of inequalities between men and women in their enjoyment of the right to health.⁹

The last two decades have seen increased international and regional efforts to combat maternal mortality and morbidity. At the international level, the most significant of these is the Millennium Declaration in 2000, when 189 countries pledged to achieve eight development goals (the Millennium Development Goals or MDGs) by 2015, including a 75 percent maternal mortality reduction compared to 1990 levels.¹⁰ In June 2009, the United Nations Human Rights Council adopted a landmark resolution on “preventable maternal mortality and morbidity and human rights,” which calls on states to renew their political commitment to eliminating preventable maternal mortality and morbidity at the local, national, regional, and international levels, including through the allocation of necessary domestic resources to health systems.¹¹ In September 2008, the European Parliament passed a resolution on maternal mortality calling upon the European Union to commit to

⁷ Estimates on the number of women who develop maternal morbidities vary. See Millennium Project, Task Force on Child Health and Maternal Health, *Who's Got the Power?*, p. 80. The WHO estimates that 30-50 times as many women suffer from maternal morbidities as die from pregnancy and childbirth. A fact sheet from the Partnership for Maternal, Newborn, and Child Health says about 30 women develop complications for every woman that dies from pregnancy and childbirth. Partnership for Maternal, Newborn, and Child Health, “Fact Sheet: Maternal Mortality (Millennium Development Goal MDG 5),” undated, http://www.who.int/pmnch/media/press_materials/fs/fs_mdg5_maternalmortality/en/index.html (accessed April 30, 2010).

⁸ Hogan et al., “Maternal Mortality for 181 Countries, 1980–2008,” p. 1.

⁹ There is no single cause of death and disability for men between the ages of 15 and 44 that is close to the magnitude of maternal death and disability. Paul Hunt and Judith Bueno De Mesquita, *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health* (New York: United Nations Population Fund (UNFPA) and University of Essex, 2007), http://www.unfpa.org/upload/lib_pub_file/750_filename_reducing_mm.pdf (accessed October 2, 2009), p. 4.

¹⁰ Other past initiatives include the 1987 Safe Motherhood Initiative and undertakings stemming from the 1994 International Conference on Population and Development.

¹¹ UN Human Rights Council, “Preventable Maternal Mortality and Morbidity and Human Rights,” Resolution A/HRC/11/L.16/REV.1.

reducing maternal and newborn mortality and morbidity both at home and abroad.¹² In April 2010, the UN Secretary-General announced the development of a Joint Action Plan to accelerate progress toward achieving the MDGs dealing with maternal and child health.¹³

In 2004, all health ministers of the African Union, with support from World Health Organization Africa Regional Office, the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF), adopted "The African Road Map for Accelerating the Attainment of the MDGs related to maternal and newborn health" (MNH Road Map).¹⁴ Its objectives are "to provide skilled attendance during pregnancy, childbirth, and the postnatal period, at all levels of the health care delivery system, and ... [to] strengthen the capacity of individuals, families and communities to improve MNH."¹⁵ Countries are expected to adopt and to develop national MNH Road Maps to scale up responses to reduce maternal and neonatal mortality and morbidity. According to UNFPA, as of July 2009 more than 40 sub-Saharan African countries had developed national MNH Road Maps and the majority of them were implementing them,¹⁶ but only eight countries had developed national strategies to address obstetric fistula as a specific subset of maternal health concerns.¹⁷

Following on this initiative, in 2006 African Heads of State adopted the Maputo Plan of Action (MPoA), which sets out a framework for countries to improve women's and girls' reproductive and maternal health.¹⁸ In 2009, the African Union launched a campaign for

¹² European Parliament, "Resolution on Maternal Mortality ahead of the UN High-level Event on the Millennium Development Goals to be held on 25 September 2008," RSP/2008/2621, September 4, 2008, <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2008-406+0+DOC+XML+Vo//EN&language=EN> (accessed April 26, 2010).

¹³ Bissera Kostova, "Secretary-General Issues Call to Action to Improve Maternal and Child Health," United Nations Radio, April 14, 2010, <http://www.unmultimedia.org/radio/english/detail/93881.html> (accessed May 3, 2010). World Health Organization, "Joint Action Plan, Delivering Maternal and Child Health: A Call to Action," Senior Strategy Meeting, April 14-15, 2010, www.who.int/entity/pmnch/events/2010/actionplanframework.pdf (accessed May 3, 2010).

¹⁴ UNFPA, "African MNH Road Maps Assessment Report," July 2009, http://www.unfpa.org/webdav/site/global/shared/documents/publications/mnh_roadmaps.pdf (accessed April 1, 2010), p. 13.

¹⁵ "Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Africa," 2004, http://www.google.co.ke/search?hl=en&q=The+African+Road+Map+for+Accelerating+the+Attainment+of+the+MDGs+related+to+maternal+and+newborn+health+%28MNH&meta=&aq=f&aql=&oq=&gs_rfai (accessed April 1, 2010), pp. 1 and 6.

¹⁶ UNFPA, "African MNH Road Maps Assessment Report," p. 14.

¹⁷ *Ibid.*, p. 25.

¹⁸ African Union, "Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action) 2007 – 2010," Sp/MIN/CAMH/5(I), http://www.unfpa.org/africa/newdocs/maputo_eng.pdf (accessed September 12, 2009). The Maputo Plan is currently under review. See African Press Organization, "AU Conference Reviews Implementation of Maputo plan of Action and Seeks to Strengthen Partnerships in MCH," April 19, 2010, <http://appablog.wordpress.com/2010/04/19/au->

accelerated reduction of maternal mortality in Africa, with the slogan “Africa Cares: No Woman should Die While Giving Life.” The campaign is meant to help countries achieve the goals of the MPoA.¹⁹

Fistula Globally

Fistula has virtually been eliminated in developed countries but is still common in the developing world. There are no worldwide, comprehensive surveys that estimate the incidence and prevalence of obstetric fistula. Currently available data by the World Health Organization (WHO) indicate that between 50,000 and 100,000 women and girls are affected each year.²⁰ This is widely viewed as an underestimate as it is based on numbers of people who sought care in hospitals and clinics, while many women with fistula do not seek care. Fistula tends to happen to the most marginalized in society: poor and illiterate young women and adolescent girls from rural areas.²¹ Consequently, fistula has largely remained a hidden condition. Many women who develop fistula have stillbirths, contributing to neonatal mortality in countries where they are predominant.²²

Causes of Fistula

Obstetric fistula is predominantly caused by prolonged obstructed labor, which is one of the five major causes of maternal mortality and accounts for 8 percent of maternal deaths

conference-reviews-implementation-of-maputo-plan-of-action-and-seeks-to-strengthen-partnerships-in-mch/ (accessed April 26, 2010).

¹⁹ See United Nations Economic Commission for Africa, “The African Union Deepens Its Campaign for Accelerated Reduction of Maternal Mortality in Africa,” <http://www.uneca.org/acgs/icpd+15/Maternal.html> (accessed October 27, 2009); and United Nations Economic Commission for Africa, “The African Union Commits to Promoting Maternal, Infant and Child Health in Africa,” <http://www.uneca.org/acgs/icpd+15/BackgroundAU.html> (accessed October 31, 2009). The Campaign’s main objective is to accelerate the availability and use of globally accessible quality services, particularly those related to sexual and reproductive health germane to the reduction of maternal and infant mortality. The African Union partners with WHO, UNFPA, and UNICEF in this campaign. Ibid.

²⁰ WHO, “10 Facts on Obstetric Fistula,” March 2010, http://www.who.int/features/factfiles/obstetric_fistula/en/ (accessed May 16, 2010). Some in-depth studies support the widely held view that the true number of women living with untreated fistula could be far more than this estimate. One study has found that in Nigeria alone, as many as one million women could be living with fistula, and another suggests that 70,000 new cases occur annually in Bangladesh. See WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development* (Geneva: WHO, 2006), http://www.who.int/making_pregnancy_safer/publications/obstetric_fistula.pdf (accessed November 27, 2009), p.4.

²¹ Family Care International and UNFPA, “Living Testimony: Obstetric Fistula and Inequities in Maternal Health,” 2007, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/living_fistula_eng.pdf (accessed April 2, 2010), p. 2.

²² Amy Tsui et al., “The Role of Delayed Childbearing in the Prevention of Obstetric Fistulas,” *International Journal of Gynecology and Obstetrics*, vol. 99 (2007), p. 98.

worldwide.²³ During the prolonged obstructed labor, the soft tissues of the birth canal are compressed between the descending head of the fetus and the woman's pelvic bone. The lack of blood flow causes tissue to die, creating a hole (fistula) between the woman's vagina and bladder (vesico-vaginal fistula or VVF) or between the vagina and rectum (recto-vaginal fistula or RVF) or both. This leaves the woman leaking urine and/or feces continuously from the vagina. Other direct causes of fistula include sexual abuse and rape, surgical trauma (iatrogenic fistula), and gynecological cancers and related radiotherapy treatment.

Most fistulas can be repaired surgically even if they are several years old. Success rates for fistula repair by experienced surgeons can be as high as 90 percent, according to UNFPA.²⁴ Successful surgery can enable women to live normal lives and even have children, but it is recommended to have a Cesarean section for future deliveries to prevent the fistula from recurring.

Early Marriage

Early marriage, marriage before the age of 18 years, is considered a major risk factor for fistula development.²⁵ Adolescent girls are particularly susceptible to obstructed labor because their pelvises are not fully developed.²⁶ Early marriage is associated not only with early childbearing, but also with reduced school attendance. This contributes to illiteracy, poverty, and low status in the community. Further, married girls and child mothers face constrained decision-making, including reproductive and maternity care choices, because they are often controlled by their husbands and relatives.²⁷ Kenya's Children's Act prohibits

²³ The term obstructed labor indicates a failure to progress due to mechanical problems such as a mismatch between the size of the presenting part of the fetus and the mother's pelvis. Some mal-presentations such as a brow presentation or a shoulder presentation will also cause obstruction. Pathological enlargement of the fetal head and ineffective uterine contractions may also obstruct labor. These different causes of difficult labor may co-exist. J. P. Neilson et al., "Obstructed Labour: Reducing Maternal Death and Disability during Pregnancy," *British Medical Bulletin*, vol. 67 (2003), pp. 191-204; Nawal Nour, "An Introduction to Maternal Mortality," *Journal of Obstetrics and Gynecology*, vol. 1, no. 2 (2008), pp. 77-81; and WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, p.3.

²⁴ UNFPA and EngenderHealth, "Obstetric Fistula Needs Assessment Report: Findings from Nine African Countries," 2003, <http://www.unfpa.org/fistula/docs/fistula-needs-assessment.pdf> (accessed November 22, 2009), p.4.

²⁵ Amy Tsui et al., "The Role of Delayed Childbearing in the Prevention of Obstetric Fistulas," p. 99. Also see WHO, "Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development," p.3. The report of the UN Secretary-General on obstetric fistula also notes that early marriage heightens the risks of obstetric fistula. UN General Assembly, "Supporting Efforts to End Obstetric Fistula, Report of the Secretary-General," (sixty-third session, item 59 of the provisional agenda, Advancement of Women), A/63/222, paras. 9-10. Malnutrition, which stunts pelvic growth, is another contributing factor to fistula development.

²⁶ *Ibid.*

²⁷ UNICEF, "Early Marriage, A Harmful Traditional Practice: A Statistical Exploration," April 2005, http://www.unicef.org/publications/files/Early_Marriage_12.lo.pdf (accessed May 14, 2010), pp. 23-24.

marriage before age 18.²⁸ Nonetheless, the 2008-09 Kenya Demographic and Health Survey (KDHS) shows that 24.6 percent of Kenyan women aged 20-24 had been married by age 18.²⁹

Female Genital Mutilation

Female genital mutilation (FGM) can also contribute to fistula occurrence, especially in communities that practice type three female circumcision or infibulation.³⁰ In many cases of infibulations, the woman is cut during childbirth to allow exit of the fetal head. This is sometimes done by unskilled traditional birth attendants who use razors or arrowheads to perform bilateral upper episiotomies, which may inadvertently extend to the bladder or rectum, causing a fistula. In Nigeria, the “gishiri” cut, a form of FGM similar to infibulation, is commonly practiced amongst the Hausa people. In Nigeria, 15 percent of obstetric fistulas are caused by this harmful practice.³¹ FGM is outlawed in Kenya, but some communities still practice it.³² Infibulation is common in North Eastern Kenya and parts of Rift Valley among the West Pokot. FGM prevalence in these regions is 97.5 percent and 32.1 percent, respectively. This is markedly higher than the 27 percent Kenyan average.³³

International Response to Fistula

There is growing global momentum by international agencies to address the problem of obstetric fistula. In 2003, UNFPA and partners launched a global Campaign to End Fistula with the target to eliminate fistula by 2015, in line with the Millennium Development Goal to improve maternal health. The global campaign focuses on prevention, treatment, and rehabilitation, and has been launched in 47 countries in Africa, Asia, and the Middle East.³⁴

²⁸ Children’s Act, art. 2 states: “early marriage” means marriage or cohabitation with a child or any arrangement made for such marriage or cohabitation.”

²⁹ Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey 2008-09* (Calverton, Maryland: KNBS and ICF Macro, 2010), p. 83.

³⁰ In the 2008 classification of FGM, WHO defines infibulation as, “narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.” WHO, *Female Genital Mutilation and Other Harmful Practices: FGM Factual Overview and Classification*, <http://www.who.int/reproductivehealth/topics/fgm/overview/en/index.html> (accessed May 24, 2010).

³¹ WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, p.36.

³² Children’s Act, art. 14.

³³ See Doctors of the World, “Partnership for Maternal and Neonatal Health: West Pokot District Child Survival and Health Program,” October 2007, http://pdf.usaid.gov/pdf_docs/PDACK514.pdf (accessed April 2, 2010), p.24, noting that traditional birth attendants and nurses working in West Pokot report that it is standard practice to cut a bilateral episiotomy in order to facilitate childbirth.

³⁴ UNFPA, “Campaign to End Fistula, Annual Report 2008,” 2009, http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/fistula_annual_report_2008.pdf (accessed March 24, 2010), p. 5.

Recognizing the lack of reliable data on fistula, one of its objectives is to conduct country-level situation analyses, including fistula prevalence, although challenges remain in collecting accurate data.³⁵ EngenderHealth, through its Fistula Care Project and with funding from the United States Agency for International Development (USAID), the UK Department for International Development (DFID), and the Bill & Melinda Gates Foundation, works on fistula prevention and treatment in 11 countries, mainly in Africa.³⁶ In 2006, the World Health Organization developed guidelines for obstetric fistula clinical management and program development to guide comprehensive country responses to fistula.³⁷

In February 2008, the General Assembly for the first time adopted a resolution on “supporting efforts to end obstetric fistula,” and called on states, the United Nations, and international financial institutions, as well as civil society organizations, to support efforts to address fistula.³⁸ The resolution also requested the UN Secretary-General to report to the General Assembly on the implementation of the resolution. In August 2008, the Secretary-General presented a report detailing efforts to address fistula at the national, regional, and international levels, and recommendations to intensify efforts to end fistula.³⁹

Key Data on Maternal Health and Fistula in Kenya

Kenya’s maternal mortality ratio, according to the 2008-09 Kenya Demographic and Health Survey, is 488 maternal deaths per 100,000 live births.⁴⁰ Maternal deaths represent 15 percent of all deaths to women of reproductive age (15-49 years). Between 294,000 and 441,000 Kenyan women and girls suffer from maternal morbidities.⁴¹ The majority of deaths are due to direct obstetric complications, including hemorrhage, sepsis, eclampsia, and

³⁵ Ibid.

³⁶ See EngenderHealth website at <http://www.fistulacare.org/pages/about-us/program-background.php> (accessed April 2, 2010).

³⁷ WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*.

³⁸ UN General Assembly, Resolution adopted by the General Assembly on the Report of the Third Committee (A/62/435), “Supporting Efforts to End Obstetric Fistula,” A/RES/62/138.

³⁹ UN General Assembly, “Supporting Efforts to End Obstetric Fistula, Report of the Secretary-General.” . Some of the recommendations to address fistula include greater investments in health systems and strengthening family planning programs including those targeting adolescent girls; skilled delivery care and emergency obstetric care. In addition, the report recommends for fistula treatment services to be offered for free or at highly subsidized rates for poor women and girls. See paras. 64(a) – (e).

⁴⁰ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. xxi.

⁴¹ Ministry of Planning and National Development, “MDGs Status Report for Kenya 2005,” undated, http://www.undg.org/archive_docs/6585-Kenya_Second_MDG_Report_-_Report.pdf (accessed October 22, 2009), p. 20.

obstructed labor, or to unsafe abortion.⁴² Unsafe abortion alone is thought to cause at least a third of all maternal deaths.⁴³ The government had set targets of having the MMR at 230 by 2005, and 170 by the end of 2010.⁴⁴

Although there has been some increase in contraceptive use in Kenya, the unmet need is still high, with wide regional variations.⁴⁵ Less than half—46 percent—of married women are using some method of family planning, and only 39 percent are using modern methods.⁴⁶ The unmet need is higher for women in rural areas.⁴⁷ The total fertility rate has slightly reduced from 4.9 children per woman in 2003 to 4.6 in 2008 according to the current Kenya Demographic and Health Survey.⁴⁸ There are wide differentials by region and education status. The total fertility rate for women in rural areas (5.2 births) is almost double that of women in urban areas (2.9 births), while that for women with at least some secondary education is 3.1, compared to 6.7 for women with no education.⁴⁹ These statistics point to gaps in the provision of family planning education and services to illiterate and rural women (discussed in more detail below).

About 92 percent of women receive some antenatal care, though take-up of antenatal care is less likely in rural areas.⁵⁰ Only 47 percent of pregnant women receive the recommended four or more antenatal visits (while only 15 percent visit within the first trimester), a decline

⁴² Ministry of State for Planning, National Development and Vision 2030, “Millennium Development Goals: Status Report for Kenya 2007,” 2008, http://www.planning.go.ke/index.php?option=com_docman&task=cat_view&gid=57&Itemid=75 (accessed December 6, 2009), p. 23.

⁴³ National Coordinating Agency for Population and Development (NCAPD) et al., “Kenya Service Provision Assessment Survey (KSPAS) 2004,” 2005, <http://www.measuredhs.com/pubs/pdf/SPA8/SPA8.pdf> (accessed December 10, 2009), p.111. The KSPAS collected information on health facility infrastructure, resources, and management systems, and on services for child health, family planning, and maternal health. Analysis of trends in maternal mortality in Kenya is complicated by the fact that previous surveys omitted the whole of northern Kenya and also differences in questions asked. See KNBS and ICF Macro, *Kenya Demographic Health Survey 2008-09*, p.273. The Kenya Demographic Health Surveys have never provided disaggregated data on the MMR.

⁴⁴ Ministry of Health, “National Reproductive Health Strategy (NRHS), 1997- 2010,” 1996, p.29. The NRHS has been revised, and contains the target of reducing the MMR to 147 by 2015. See Ministry of Public Health and Sanitation and Ministry of Medical Services, *National Reproductive Health Strategy 2009 – 2015*, August 2009, p. 65.

⁴⁵ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, pp. xix-xx. Unmet need for family planning is the gap between women’s desire to delay or avoid having children and their actual use of contraception. WHO et al., *the Millennium Development Goals Report 2009*, p. 23.

⁴⁶ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. xx.

⁴⁷ *Ibid.*, p. 96.

⁴⁸ *Ibid.*, p. xix.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*, p. 113.

from 52 percent in the 2003 KDHS.⁵¹ Most deliveries take place at home: only 44 percent of women deliver with a skilled birth attendant and 43 percent of such deliveries take place in a health facility.⁵² Traditional birth attendants assist in 28 percent of home deliveries.⁵³

In 2004, the Ministry of Health and UNFPA conducted a needs assessment of obstetric fistula in Kenya, marking the first major step taken by the government to address obstetric fistula. The 2004 research indicated that fistula affects approximately 3,000 women and girls every year (calculated at the rate of one to two cases per 1,000 deliveries). This needs assessment estimated that there is a backlog of up to 300,000 untreated fistula cases.⁵⁴ Doubts exist about these estimates; some experts think that the prevalence could be higher while others argue that some progress has been made both in terms of repairing existing cases and in improving access to maternity care. Therefore the prevalence could be lower.⁵⁵

Relevant Policies

To its credit, the Kenyan government has taken positive steps to address maternal mortality and morbidity by developing various strategies, policies, and guidelines to address women's reproductive and maternal health. Few of these expressly address obstetric fistula, however.

The strategies, policies, and guidelines most relevant to fistula are described in detail in [Appendix 1](#). They include several on reproductive health (the National Reproductive Health Strategy and the National Reproductive Health Policy); family planning (the Family Planning

⁵¹ Ibid., p. 116. UNICEF and WHO recommend a minimum of four antenatal visits. WHO et al., *The Millennium Development Goals Report*, p. 27.

⁵² KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 119. This is a small increase from 42 percent in the 1998 KDHS. WHO defines a skilled birth attendant as “an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.” WHO, “Making Pregnancy Safer: The Critical Role of the Skilled Attendant. A Joint Statement by WHO, ICM and FIGO,” 2004, <http://whqlibdoc.who.int/publications/2004/9241591692.pdf> (accessed March 2, 2010), p. 1. Skilled attendance requires that the health care provider has at her disposal the necessary equipment and medicines, and a functioning referral system for emergency obstetric care. Ibid., p. 2.

⁵³ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 122. A traditional birth attendant does not meet the definition of a skilled birth attendant because they are not formally trained as midwives.

⁵⁴ Ministry of Health and UNFPA, “Needs Assessment of Obstetric Fistula in Kenya,” 2004, http://www.fistules.org/docs/na_kenya.pdf (accessed November 15, 2009), p. 14. The needs assessment was conducted in Nairobi and four poor access districts staggered across four provinces. It is unclear how the number on backlog of cases was arrived at.

⁵⁵ For example Dr. Geoffrey Okumu of UNFPA told Human Rights Watch, “We thought it [obstetric fistula] was common in poor access districts but it is common in other areas, for example in Muranga. It may be more widespread than we previously thought.” Human Rights Watch interview with Dr. Geoffrey Okumu, fistula program coordinator, UNFPA, Nairobi, November 19, 2009. The needs assessment quotes a doctor in one of the study districts (Mwingi) saying that fistula cases are as many as two to three per 100 deliveries in the area. Ibid., p. 18.

Guidelines for Service Providers); adolescent health (the Adolescent Reproductive Health and Development Policy and the National Guidelines for Provision of Youth-Friendly Services); and on reconfiguring health care delivery services to better serve poor and rural communities (including the National Health Sector Strategic Plan, the Kenya Essential Package for Health, the Community Strategy, and the Community Midwifery Approach).

While there is no national strategy on fistula, in 2006 the Ministry of Health did issue the “Kenya National Obstetric Fistulae Training Curriculum for Health Care Workers.”⁵⁶ The curriculum is a helpful tool for doctors, nurses, and other medical and social workers involved in managing fistula, but is far from a national policy or strategy.

Two of the efforts to revamp health care delivery in Kenya that are most relevant to fistula are the Community Strategy and the Community Midwifery Approach. Both have experienced serious delays and difficulties in implementation; if these are overcome, the strategies could reduce many of the barriers to information and to effective care which contribute to fistula’s prevalence.

Community Strategy

In 2006 the Ministry of Health launched the Community Strategy, which has been lauded as a viable approach to improve service delivery at the lowest levels of the health care system (community level or level one) that serve mainly rural and poor communities. It envisages building the capacity of households not only to demand services from all health providers, but to know and progressively realize their rights to equitable, good quality health care. The strategy aims, among other things, to reduce child and maternal deaths.⁵⁷ Three categories of services should be provided at the community level: disease prevention and control to reduce morbidity, disability and mortality; hygiene and environmental sanitation; and family health services to expand family planning, maternal, child, and youth services.⁵⁸ There are two categories of personnel promoting health at the community level: community health workers (CHWs) who work on a volunteer basis, and community health extension workers (CHEWs) who are paid government employees and supervise CHWs.

⁵⁶ Ministry of Health, “Kenya National Obstetric Fistulae Training Curriculum for Health Care Workers,” 2006.

⁵⁷ Ministry of Health, “Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level,” 2007, p. 23; Ministry of Health, “Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1: A Manual for Training Community Health Workers,” 2007, p.3.

⁵⁸ Ministry of Health, “Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services,” 2006, p.19.

One focus area in the Community Strategy is to address challenges related to decision-making for maternity care, which contribute to delay in seeking skilled care in case of complications.⁵⁹ Many Kenyan women and girls have these decisions made for them by husbands or mothers-in-law, or other relatives. This occurs for several reasons, including the low status of women in society, poverty, and illiteracy, as demonstrated by Kenyan health survey work.⁶⁰ Part of the Strategy includes educating men about safe motherhood, and training women to speak out about their needs, components which are not currently being fulfilled.⁶¹ Approaches have been insufficiently sensitive to gender power differentials, according to those who have evaluated outcomes thus far.⁶²

Profile of Kanyua L.: family decision to delay seeking care led to fistula, Machakos, December 6, 2009.

“I started labor on a Saturday at about 6 p.m., and immediately told my mother-in-law. I told her to take me to hospital but she said ‘the nurses just tell you to go and deliver in a hospital but there is nothing wrong in delivering at home. I delivered all my children safely at home and so will you.’ I did not say anything to her because when one is sick you do not take yourself to hospital. You follow what others tell you. My mother-in-law left and came back with a traditional birth attendant (TBA). The TBA examined me and said all was well, and that I would deliver in a few hours. She told my mother-in-law to keep an eye on me, and to call her when the baby’s head appears, then she left. I was in so much pain the whole night. My mother-in-law went for the TBA the following day around 2 p.m. The TBA examined me by putting her hands in my birth canal and said I had dilated well. She kept asking me to push. I pushed but the baby did not come out. This continued until about 11 p.m. when my husband said we should go to hospital. However, we couldn’t get a vehicle because it was at night. In the morning, we went to Wote dispensary and they said the baby was dead. They took me to Machakos Hospital. At Machakos, I was operated on to remove the dead baby. Two days later, I realized water [urine] was just coming out.”

⁵⁹ Ministry of Health, “Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level,” 2007, p. 24.

⁶⁰ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 123.

⁶¹ Ministry of Planning and National Development, “MDGs Status Report for Kenya 2005,” p. 21.

⁶² Development Partners in Health Kenya, “Review of AOP II Implementation – Social Development Assessment Summary,” October 2007, http://webcache.googleusercontent.com/search?q=cache:oPawEou4N_IJ:www.hdwg-kenya.com/new/index.php%3Foption%3Dcom_docman%26task%3Ddoc_download%26Itemid%3D%26gid%3D145+Review+of+AOP+II+Implementation+%E2%80%93+Social+Development+Assessment+Summary,%E2%80%9D&cd=1&hl=en&ct=clnk&gl=ke (accessed January 29, 2010). An NGO implementing programs on maternal health in urban slums in Nairobi commented: “During antenatal care we ask women where she will deliver and she says my husband will know.” Human Rights Watch interview with [name withheld], Nairobi, December 4, 2009. A nurse noted, “Many husbands still determine when and where their wives go to give birth and this is causing many problems for them [pregnant women].” Human Rights Watch interview with Rose Odeny, reproductive health coordinator, Migori District Hospital, Nairobi, February 4, 2010.

Personnel and resource challenges have dogged implementation of the Community Strategy as well, including low motivation of CHWs because they are not paid, inadequate training of CHWs in key messages, and service providers' poor understanding of the essential services package concept.⁶³ Community health extension workers and Community Health workers are trained on a range of reproductive health issues, including how to refer women for obstetric care. They are not trained on fistula.⁶⁴

The Community Strategy presents an opportunity to reach communities with information on fistula, to identify women living with fistula, and to refer them for treatment. CHEWs and CHWs can help to collect useful data on fistula in communities as well. Data on fistula is not collected routinely in health facilities, nor is there analysis of its causes. The 2008-09 Kenya Demographic and Health Survey—which focused on reproductive health—failed to collect conclusive data on fistula although UNFPA had provided money for this purpose.⁶⁵ Data collection is an essential component of accountability, which, as will be shown further on, is critical to ensure that these rights violations are remedied.⁶⁶

Community Midwifery Approach

In 2005 the Department of Reproductive Health in what is now the Ministry of Public Health and Sanitation, the Population Council, and the Nursing Council of Kenya developed and piloted the Community Midwifery Approach (CMA) in an effort to increase skilled attendance

⁶³ Paulinus Lingani and Ncube Sikosana, “National Health Sector Strategic Plan II: Report on the External Health Sector Evaluation of the Annual Operational Plan 2 (July 2006 – June 2007), Thematic Area, Health Service Delivery,” October 2007, www.hdwg-kenya.com/new/index.php?option=com_docman (accessed January 29, 2010), p. 12.

⁶⁴ In 2007, the Ministry of Health developed Community Strategy Implementation Guidelines that contain key health messages to be disseminated at the community level. Under pregnancy, delivery, and childbirth, key messages include danger signs during pregnancy, but they are not comprehensive. For example, none of the key messages address the post-partum period. Incontinence, a symptom of obstetric fistula, is not mentioned. Ministry of Health, “Key Health Messages for Level 1 of the Essential Package for Health: A Manual for Community Health Extension Workers and Community Health Workers,” 2007.

⁶⁵ In addition to lack of reliable data on fistula, there is also poor monitoring of existing programs to be able to determine what, if any, progress is being made. The head of the Department of Reproductive Health in the Ministry of Public Health and Sanitation linked this to poor coordination. He remarked, “I want to stress better coordination. If today as head of the Department of Reproductive Health I was asked what the statistics are, I don’t have.... How do we monitor our fistula operations? Are we anywhere near clearing the backlog? How many surgeries are we doing and are we on track? We need to publish and share best practices.” Dr. Issak Bashir, speaking at the Obstetric Fistula Stakeholders’ Meeting, School of Monetary Studies, Nairobi, February 4, 2009, attended by Human Rights Watch Researcher.

⁶⁶ Obstetric fistula is considered a “near miss” of maternal mortality, and analyzing its medical, socio-economic, and cultural causes is critical to improving the quality of maternal care and accountability of the health care system. The Africa Medical Research Foundation and the Freedom from Fistula Foundation have been collecting stories of fistula survivors they support for repairs. Such information, as well as other data, is important in designing prevention strategies and can be particularly helpful in integrating fistula into the Community Strategy. The Kenya government should also integrate inquiries on fistula into future demographic and health surveys.

at birth and reduce obstetric complications.⁶⁷ The CMA involves identifying health professionals who meet certain qualifications who are then given training on technical developments to be able to provide home-based skilled attendance at delivery and essential newborn and postpartum care.⁶⁸

Community midwives are not government employees but they are formally linked to government health facilities and supervised by a government employee: the District Public Health Nurse. They depend entirely on community members' ability to pay them for the services provided.⁶⁹ Some have clinics, while others operate from their homes. Some community midwives often assist the antenatal care clinics to which they are linked.⁷⁰ The government provides community midwives with basic reproductive health commodities such as oral and injectable contraceptives, condoms, gloves, needles, and syringes.⁷¹ The Community Midwifery Approach is linked to the Community Strategy, and the midwives work closely with community health workers and community health extension workers.

The CMA is also intended to address the problem of traditional birth attendants (TBAs). According to the 2008-09 Kenya Demographic and Health Survey, TBAs attend 28 percent of all births in Kenya, the same number of births as those assisted by nurses and midwives.⁷²

⁶⁷ Subsequently, UNFPA has supported the government to extend the CMA to four districts in three provinces as part of the Campaign to End Fistula. WHO, the UK Department for International Development (DFID), and the United States Agency for International Development (USAID) also support the government to expand the CMA. Population Council estimates that by the end of 2008, 24 districts in Kenya were running community midwifery programs. *Ibid.*, p. ii. WHO, DFID and USAID have been supporting training of community midwives. UNFPA and Population Council, "Obstetric Fistula: Can Community Midwives Make a Difference?," p. ii.

⁶⁸ For a person to qualify for recruitment as a community midwife, he or she must meet the following criteria: registered or enrolled nurse midwife; registered clinical officer (with reproductive health experience); medical practitioner; evidence of retention on a professional register (Nursing Council of Kenya, Kenyan Clinical Officers Council, or Medical Practitioners and Dentists Board); retired or out of employment; obstetric skills; and permanent residency within the community to be served, or prepared to live in that community. Annie Mwangi and Charlotte Warren, "Taking Critical Services to the Home: Scaling-up Home-based Maternal and Postnatal Care, including Family Planning, through Community Midwifery in Kenya," 2008, http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_CommMidwife.pdf (accessed April 6, 2010), p. 7.

⁶⁹ There are no guidelines for charges on the various services offered. Population Council estimates that the minimum cost of supplies used for the whole package of care (antenatal care, delivery, and postnatal care) is US\$15; and that average profit margin for providing these services is around \$5 per client. Community midwives charge higher fees than health facilities in the provision of certain services and sometimes even charge for otherwise free services in public health facilities. However, they accept payment in installments and in kind (for example exchange of services with farm produce and livestock, labor or rent-free land). Their services also reduce money and time spent on traveling to facilities. *Ibid.*, p. 22.

⁷⁰ *Ibid.*, p. 3.

⁷¹ To receive new stocks of supplies, the community midwife is expected to forward a report every month showing the utilization and anticipated need for more commodities. When commodities are not available in the district stores, some midwives purchase the commodity privately and then provide it at cost to the clients. Population Council notes that supplies are occasionally hampered by commodity stock-outs. *Ibid.*, p. 13.

⁷² KBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 122.

In some areas in Kenya, TBAs attend to more deliveries than skilled professionals. In Western and North Eastern provinces, for example, TBAs attend 45 percent and 64 percent of deliveries respectively.⁷³ The reliance on TBAs over skilled attendants contributes to the occurrence of obstetric fistula and maternal deaths, since they are not qualified to handle obstructed labor or other complications during delivery.⁷⁴ We spoke to 14 women and girls who were kept in labor for more than one day by TBAs without being referred to a health facility and who developed fistula as a result.

The Community Midwifery Approach and the Community Strategy are intended to help incorporate TBAs into the wider health system in social support roles, and thus to increase skilled attendance at births.⁷⁵ This can prevent cases of fistula occurring.⁷⁶ Two major challenges concern expansion to cover the whole country and sustainability of the CMA, particularly payment of the midwives. Many women have very limited funds to pay the midwives. If women are unable to meet the costs, then community midwives are unable to replenish their supplies or continue to be motivated to provide services.⁷⁷

⁷³ Ibid.

⁷⁴ Traditional birth attendants tend to be elderly women often with no formal education, in the communities.

⁷⁵ As recommended by the Population Council. Ministry of Health et al., “Traditional Birth Attendants in Maternal Health Programmes,” p. 2. The Community Midwifery Strategy is one such strategy. Although viable, as earlier noted, the program is fraught with challenges including human resource and financial ones.

⁷⁶ A study conducted by UNFPA and the Population Council in four districts in Kenya on the capability of community midwives to prevent obstetric fistula from occurring concluded that “100% of the women managed by the community midwives with a diagnosis of obstructed labor were promptly referred and none developed a fistula.” UNFPA and Population Council, “Obstetric Fistula: Can Community Midwives Make a Difference?,” p. iv..

⁷⁷ Mwangi and Warren, “Taking Critical Services to the Home,” p. 5; Human Rights Watch interview with Esther Mbinzi, nurse in the gynecology ward, Machakos General Hospital, Machakos, December 4, 2009., 2010; Human Rights Watch interview with Charity Ndwiga, program officer, Population Council, Nairobi, March 3, 2010.

II. Impact on the Lives of Women and Girls in Kenya

Profile of Kwamboka W., Kisii, November 11, 2009.

“I got pregnant when I was 13 years old. I was in form one, and was forced to drop out of school. When I started labor, my mum and my aunt immediately took me to a private clinic near home. We arrived at about 6 p.m. The doctor checked me and told me I was doing well and should deliver by 2 p.m. the following day, but I did not. At 6 a.m. the following day I felt the urge to push and I started pushing. At about 11 a.m. he said the baby was coming out because he could see hair. I continued pushing, but the baby did not come out. An hour later, my mum insisted that I go to hospital. She took me to Ogembo hospital. It took us one hour to get there. At Ogembo the nurse checked me and said the baby was dead and referred me to Kisii General [Hospital]. We arrived there at 6 p.m. The doctor examined me and said the baby was dead, and I should be taken to theatre for surgery to remove the baby.”

“I realized later while I was at the hospital that I could not control urine. I stayed in hospital for two months but I did not heal. Back home, my parents collected money from friends and we went to a doctor at Kisii General. The doctor told me to look for KES 10,000 (US\$130) for treatment. My parents did not have the money, and people refused to help again. My parents lost hope. So I continued to pray and just stayed at home. I have had this problem for seven years. When I went home, I was so traumatized. I had never heard of this thing [fistula] before. I thought it was only me with it. I thought I should kill myself. You can’t walk with people. They laugh at you. You can’t travel, you are constantly in pain. It is so uncomfortable when you sleep. You go near people and they say urine smells and they are looking directly at you and talking in low tones; it hurt so much I thought I should die. You can’t work because you are in pain; you are always wet and washing clothes. Your work is just washing pieces of rugs. It is difficult to walk. You feel like your thighs are on fire. You cannot eat comfortably because you fear the urine will be too much. I cannot get into a relationship with a man because I feel embarrassed because I have so much urine coming out. My mother tells me, ‘you can’t get married; how can you go to someone’s home when you are like this? They will despise you.’ I pity myself so much. My biggest fear is that I may never get a child. I look at my age-mates who are married with children and I feel so worthless.”

Physical and Psychological Consequences

Without surgical repair, the physical consequences of fistula are severe, and can include a fetid odor, frequent pelvic or urinary infections, painful genital ulcerations, burning of thighs from the constant wetness, infertility, nerve damage to the legs, and sometimes early

mortality. Many women interviewed by Human Rights Watch complained of difficulty walking because the skin on their thighs stung so intensely. Many women suffering from obstetric fistula limit their intake of water and food because they do not want to leak. This can lead to dehydration and malnutrition.⁷⁸ The majority of women and girls we interviewed who were married or in sexual relationships complained of pain and discomfort during sex.

Fistula has a huge psychological impact on women and girls, sometimes leading to depression and suicide. Most women we interviewed described feelings of hopelessness, self-hatred, guilt, and sadness, especially because they are stigmatized and think their condition is untreatable. One woman told us, “You are always sad because every time you are washing clothes, you stain everything and you smell.”⁷⁹ Amolo A. described how hopeless she felt before she had successful fistula surgery in 2007: “I was raped, the baby was dead, I was leaking urine and I couldn’t be treated. I felt so hopeless. My life was just useless. I was only 19. My age mates were getting married, and moving on with their lives and I was an outcast.... I was just a burden to everyone.”⁸⁰

Social Consequences

Women and girls living with fistula are often ostracized largely because of the foul odor they produce; almost all women and girls we interviewed said they have experienced stigma due to their odor. Nyasuguta J. told us, “My cousin is so stigmatized. They say ‘she is just feces’ and that she should not go near visitors. Her brothers disowned her. When they see her approaching they say ‘the one with feces has returned.’”⁸¹ Another woman told us, “I confided in a friend once.... She insulted me and ridiculed me.... She called me a mobile pit latrine.”⁸² Awino D. said, “People laugh at me saying I am urinating everywhere. They even sang about me in a circumcision song saying ‘someone’s wife urinates on the mattress.’ I asked my husband ‘how come your friends are ridiculing me?’”⁸³

Fistula is more stigmatized when, due to misinformation, it is linked to other taboo conditions such as HIV/AIDS, abortion, and infertility. Wangui K. told us, “People ... say ‘she

⁷⁸ Almost all the women and girls we interviewed told us that they often limit intake of water, beverages, and food in attempt to reduce leakage of urine or stool.

⁷⁹ Human Rights Watch interview with Kemunto S., Kisii, November 11, 2009.

⁸⁰ Human Rights Watch interview with Amolo A., Nairobi, November 27, 2009.

⁸¹ Human Rights Watch interview with Nyasuguta J., Kisii, November 11, 2009.

⁸² Human Rights Watch interview with Amolo A., Nairobi, November 27, 2009.

⁸³ Human Rights Watch interview with Awino D., Nairobi, December 2, 2009.

has been aborting. Why can't the husband chase her and marry another woman who can give birth?"⁸⁴ Muthoni M., who is living with HIV and fistula, was abused by her family and abandoned by her husband. She said:

When I went home, he saw my condition and left home. He said it was my problem.... The mother wants him to marry another woman. I am HIV positive. That's why they despise me more.... I don't know what I will do when I go back home because I can't work. I think I will go back to my parents.... I was so mistreated I thought of killing myself. You know this is a bad combination. They say even if I go to Nairobi I won't get better, I will die.⁸⁵

Fistula survivors are also thought by some to be bewitched or cursed, or may be accused of being promiscuous. Women and girls with fistula are often abused, beaten, abandoned, and divorced by their husbands or are isolated in their homes or shacks outside their homes. Rose Odeny, a nurse at Migori District Hospital who works with community midwives in the district told us, "Most women [with fistula] in Migori have been sent away from their [marital] homes. I find most of them at their parental home. Even when they are not sent away, the way they are treated makes them to pack and leave."⁸⁶ One woman said her husband beats her because he thinks she is lazy: "He says ... 'fellow women are doing business but you are just sitting at home.'"⁸⁷ Awino D., who had just left her abusive husband before our interview, told us,

I stayed with my husband for about five years. There was so much violence.... At home they insulted me that I am filling the toilet and yet I have no child. They said that their son should marry another wife because I am wasting his time.... There was a day he told me as he was beating me, 'leave so that I can marry again.' I left him in August 2009. He beat me and I decided I had had enough and went back to my parents.⁸⁸

⁸⁴ Human Rights Watch interview with Wangui K., Kisii, November 10, 2009.

⁸⁵ Human Rights Watch interview with Muthoni M., Machakos, December 6, 2009.

⁸⁶ Human Rights Watch interview with Rose Odeny, reproductive health coordinator, Migori District Hospital, Nairobi, February 4, 2010.

⁸⁷ Human Rights Watch interview with Beatrice B., Kisumu December 9, 2009.

⁸⁸ Human Rights Watch interview with Awino D., Nairobi, December 2, 2009.

Fistula often leads to loss of social belonging and association. Many women and girls with fistula lead isolated lives, confining themselves to their homes due to the stigma and shame attached to the illness. A large number of those we interviewed did not go to church, the market, or other social places. For example, Fatuma H. told us, “When you have this problem you have a lot of worries. You don’t have a lot of comfort. You can’t mix freely with other people. You feel guilty to mix with them. You fear the thing [the rugs used to keep dry] will come out and embarrass you. You can’t even go to church.”⁸⁹ About five of the girls we interviewed said they would have wanted to return to school after giving birth, but fistula made it impossible.

Economic Consequences

Fistula places a huge financial burden on poor families. Frequent infections mean women and girls regularly need medical attention. Women also told us that they need petroleum jelly to soothe the burning on their thighs because they cannot afford regular medical care for this. Almost all the women we spoke to said they could not afford to buy sanitary pads and instead used rugs and pieces of old clothes to control the constant trickle of urine and feces. It is also expensive to keep the rugs clean. Women told us that they needed to bathe, change, and wash their rugs and clothes several times a day to stay clean. For this, they need extra supply of soap, which is expensive. Gesare J. told us, “It is expensive to have this problem. At night, I have to keep a basin with Omo [washing powder] and water so that I use it and then pour it in the morning, otherwise the whole house will smell. It is expensive to keep yourself clean, you need to bathe and wash clothes all the time. You need Vaseline [petroleum jelly] to apply to the thighs. It is really hard.”⁹⁰

Women and girls with fistula may also lose property when they are divorced or chased away by their husbands. All the women and girls we interviewed who had left or been chased away by their husbands told us they left with no share of the family property. Nyakiriro C. told us, “When I got the problem, my husband told me to go back to my mother.... I left with no property. He sold the land and the livestock after I left.”⁹¹ Another one told us, “I left home with nothing. We did not have much but I did not get my share of [the property].”⁹²

⁸⁹ Human Rights Watch interview with Fatuma H., Kusumu, December 9, 2009.

⁹⁰ Human Rights Watch interview with Gesare J., Kisii, November 11, 2009.

⁹¹ Human Rights Watch interview with Nyakiriro C., Kisii, November 11, 2009.

⁹² Human Rights Watch interview with Nyaboke H., Kisii, November 10, 2009.

Fistula decreases women's and girls' abilities to farm or do other economic activities. Although some women told us that they were able to work on their farms despite the pain and discomfort they suffered, others said they were not able to. Some lose jobs or are denied work when employers discover that they have fistula. For example, Nyaboke H. told us,

My husband chased me away when I got this problem [fistula]. He used to beat me a lot. When I went back to my parents, my sister-in-law also became abusive saying she did not want a dirty smelly person in the home. I left, went to a nearby town, and rented a house. I started doing casual jobs like washing clothes and fetching water, but whenever it was discovered that I had a problem of [controlling] urine, I was chased away. Before long, everybody knew about my problem and I stopped getting work. I used to lock myself in the house and cry the whole night, and sleep hungry.⁹³

Other women quit their jobs out of shame. Beatrice N. told us, "I felt bad. I felt like keeping to myself. I stopped going to church. I stopped my cleaning job at Maseno University and stayed at home because I felt ashamed."⁹⁴ Because of the shame and guilt women feel as a result of having fistula, they are reluctant to look for work or ask for financial support from their husbands and other family members.

⁹³ Human Rights Watch interview with Nyaboke H., Kisii, November 10, 2009.

⁹⁴ Human Rights Watch interview with Beatrice N., Kisii, November 11, 2009.

III. Kenya's Obligations under International, Regional, and National Law

The Kenyan government has obligations under international, regional, and national law to protect the human rights of women and girls, including rights relating to their reproductive and maternal health.

Violations of human rights protections and standards guaranteed by national, regional, and international laws contribute to the occurrence of fistula and impede its treatment and elimination. The rights that Human Rights Watch found to have been routinely violated among women and girls suffering from fistula include the right to the highest attainable standard of health, the right to equality and non-discrimination, the right to information, and the right to a remedy.

Kenya is a state party to several international and regional human rights treaties that establish a right to the highest attainable standard of health and provide important protections for the rights of women and girls, including reproductive and maternal health. At the international level, Kenya has ratified the International Covenant on Civil and Political Rights (ICCPR),⁹⁵ the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁹⁶ the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),⁹⁷ Convention on the Rights of the Child (CRC),⁹⁸ and the Convention on the Rights of Persons with Disabilities (CRPD).⁹⁹

⁹⁵ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc A/6316 (1966) 999 U.N.T.S. 171, entered into force March 23, 1976, acceded to by Kenya May 1, 1972.

⁹⁶ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, acceded to by Kenya May 1, 1972.

⁹⁷ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, acceded to by Kenya March 9, 1984.

⁹⁸ Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, ratified December 20, 1990. The Children's Act aims to implement international law by "[giving] effect to the principles of the CRC and the African Charter on the Rights and Welfare of the Child." Children's Act, introduction.

⁹⁹ Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006 G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008, U.N. Doc. A/61/611, art. 16(1), ratified by Kenya May 19, 2008.

At the regional level, Kenya has ratified the African Charter on Human and Peoples' Rights (African Charter),¹⁰⁰ and the African Charter on the Rights and Welfare of the Child,¹⁰¹ and signed but not ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).¹⁰²

Kenyan law has important protections for the realization of the reproductive and maternal health rights of women and girls. The Kenya Constitution prohibits discrimination on the grounds of sex, residence, or place of origin.¹⁰³ Provisions in the Children's Act include the right to non-discrimination and to health. On health, it states that "Every child shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government."¹⁰⁴ The Act further states that "The Government shall take steps to the maximum of its available resources with a view to achieving progressively the full realization of the rights of the child."¹⁰⁵

The Right to Health

Health is a fundamental human right enshrined in numerous international human rights instruments, including the Universal Declaration of Human Rights, the ICESCR, the African Charter, the CRC, and CEDAW. The ICESCR specifies that everyone has a right "to the enjoyment of the highest attainable standard of physical and mental health."¹⁰⁶

Because states have different levels of resources, international law does not mandate the kind of health care to be provided, beyond certain minimum standards. The ICESCR provides that the rights guaranteed by it, including the right to health, are subject to "progressive realization," meaning that a state should "take steps to the maximum of its available resources" to achieve the full realization of the right to health. States are obliged to

¹⁰⁰ The African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986, acceded to by Kenya January 23, 1992.

¹⁰¹ African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), November 29, 1999, ratified July 25, 2000.

¹⁰² Protocol to the African Charter on Human and Peoples' Rights on The Rights of Women in Africa (the Maputo Protocol), adopted July 11, 2003, entered into force November 2005, signed by Kenya December 17, 2003.

¹⁰³ Constitution of Kenya, adopted 1963, amended 1999, <http://www.usig.org/countryinfo/laws/Kenya/Constitution.pdf> (accessed May 20, 2010), Chapter V, para. 70(a).

¹⁰⁴ Children's Act, art. 9.

¹⁰⁵ *Ibid.*, art. 3.

¹⁰⁶ ICESCR, art. 12(1).

endeavor to create conditions that would assure access to all medical services and medical attention in the event of sickness.¹⁰⁷

The Committee on Economic, Social and Cultural Rights, which oversees implementation of the ICESCR by states parties, has provided examples of what may constitute a failure of a government to fulfill its obligations with respect to the right to health. The examples include failing to adopt or implement a national health policy designed to ensure the right to health for everyone, insufficient expenditure or misallocation of available public resources which lead to the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized, and the failure to reduce infant and maternal mortality rates.¹⁰⁸

The Committee has also set out what it considers to be the essential elements of the right to health (availability, accessibility, acceptability and quality), as well as minimum “core obligations” of governments. The basic elements of this right and the minimum core obligations are described in detail in General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. That General Comment emphasizes the minimum core obligations of a government in terms of health care, which include, for example, “the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups” and “equitable distribution of all health facilities, goods, and services.”¹⁰⁹ On economic access, the Committee states:

Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.¹¹⁰

¹⁰⁷ ICESCR, art. 12(2).

¹⁰⁸ See UN Committee on Economic, Social and Cultural Rights, “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,” General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000).

¹⁰⁹ *Ibid.*, para. 43.

¹¹⁰ CESCR, General Comment No. 14, para. 12(b). The former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health, Paul Hunt, developed some indicators to measure progress with regard to the realization of the right to health. UN Commission on Human Rights, “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health,” E/CN.4/2006/48, March 3, 2006.

The ICESCR stipulates that states parties must take steps to reduce the stillbirth rate and infant mortality and to provide for the healthy development of the child.¹¹¹ The Committee on Economic, Social and Cultural Rights states that ensuring “reproductive, maternal (pre-natal as well as post-natal) and child health care” is of comparable priority to the core obligations.¹¹² Lowering of maternal mortality is identified as a “major goal” for governments.¹¹³

Building upon the provisions of the ICESCR, the Convention on the Rights of the Child also addresses the obligations of states parties in respect of the right to health of children, and states that governments must act in the areas of child health and pre- and post-natal health care, in particular primary health care.¹¹⁴ Similarly, CEDAW protects the right of women to access health care without discrimination and to get “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”¹¹⁵ The CEDAW Committee, a body of experts that monitors implementation of the convention, notes that high maternal mortality and morbidity “provide an important indication for States parties of possible breaches of their duties to ensure women’s access to health care.”¹¹⁶

The Right to Information

Information is a key aspect of the right to health and is critical to women’s reproductive health. The Committee on Economic, Social and Cultural Rights notes that the obligation to fulfill the right to health requires the state to promote health by undertaking research, disseminating information on harmful traditional practices and availability of services, training health providers to respond to the specific needs of vulnerable or marginalized

¹¹¹ ICESCR, art. 12.2(a). It states, “The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.” According to the UN Committee on Economic, Social and Cultural Rights, this means to “improve child and maternal health, sexual and reproductive health services generally, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”

¹¹² ICESCR, General Comment No. 14, para. 44.

¹¹³ ICESCR, General Comment No. 14, para. 21. The Committee also states that “It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.”Ibid.

¹¹⁴ CRC, art. 24(d).

¹¹⁵ CEDAW, art. 12(2).

¹¹⁶ CEDAW Committee, General Recommendation 24: Women and Health, UN GAOR, 1999, UN Doc. No. A/54/38/Rev.1 para. 17.

groups, and supporting people to make informed choices about their health.¹¹⁷ The CEDAW Committee has called on states parties to take steps under the right to health, in particular to “prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance.”¹¹⁸ The Convention on the Rights of Persons with Disabilities requires states to provide “access to age-appropriate information, reproductive and family planning education.”¹¹⁹

The CRC provides for the child’s right to “seek, receive and impart information of all kinds”¹²⁰ and requires states to ensure access to child-friendly information about preventive and health-promoting behavior, and to abolish harmful traditional practices such as early marriage and female genital mutilation.¹²¹ The African Charter recognizes that every individual has “the right to receive information” and “the right to education.”¹²² The Maputo Protocol specifically includes “the right to have family planning education” and further obligates governments to “provide adequate, affordable and accessible health services, including information, education and communication program to women especially those in rural areas.”¹²³ The Committee on Economic, Social and Cultural Rights recognized that the right to health includes the right of access to information and health-related education.¹²⁴ The particular needs of women in relation to access to health-related information have also been highlighted by the CEDAW Committee and the UN Special Rapporteur on Health, who has stated that one of the factors that make women more vulnerable to ill-health is a lack of access to information.¹²⁵

¹¹⁷ CESCR, General Comment No. 14, para. 37.

¹¹⁸ CEDAW Committee, General Recommendation No. 24, para. 31.

¹¹⁹ CRPD, arts 23(b) and 25(a).

¹²⁰ CRC, art. 13.

¹²¹ See CESCR, General Comment No. 14, para. 22.

¹²² Banjul Charter, arts. 9(1) and 17(1).

¹²³ Maputo Protocol, art. 14.

¹²⁴ CESCR, General Comment No. 14, para 12(b).

¹²⁵ UN Commission on Human Rights, “The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31”, E/CN.4/2003/58, February 13, 2003 and CEDAW Committee, General Recommendation No. 24, para. 18.

Right to Equality and Non-Discrimination

Human rights law and standards guarantee women the right to equality and non-discrimination. CEDAW is the treaty that sets out most comprehensively the areas in which governments should be working to eliminate discrimination against women, and in article 12 specifically addresses the area of health. Under CEDAW states parties are required to “eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to reproductive health.”¹²⁶ The Maputo Protocol also calls upon states to reform laws and practices that discriminate against women, while the Convention on the Rights of the Child guarantees children the right to be free from discrimination.¹²⁷ Under the principle of non-discrimination, adolescents should enjoy the same rights to reproductive health services as adults, as consistent with their evolving capacities.

Because only women require health care services for pregnancy and childbirth, states are under obligation to take special measures to make such services available and accessible, while ensuring that they are acceptable and of adequate quality. Failure to make efforts to do so is a form of discrimination. Certain groups of women face not only gender discrimination, but experience discrimination due to their economic status, geographic location, and age. Under article 14 of the CEDAW, governments must make special efforts to ensure that women in rural communities are not disadvantaged, particularly regarding “access to adequate health care facilities, including information, counseling and services in family planning.”¹²⁸

The Right to a Remedy

Regional and international treaties establish the basic right of individuals to an effective remedy when their human rights have been violated. The Committee on Economic, Social and Cultural Rights has recognized the rights of victims of violations of the right to health to access judicial or other remedies and adequate reparation in “the form of restitution, compensation, satisfaction or guarantees of non-repetition.”¹²⁹ Likewise, the Maputo Protocol specifically recognizes women’s right to redress, requiring states to “provide for appropriate remedies to any woman whose rights ... have been violated ... [and] ensure that

¹²⁶ CEDAW, art. 12(1).

¹²⁷ CRC, art. 2.

¹²⁸ *Ibid.*, art. 2(1).

¹²⁹ CESCR, General Comment No. 14, para. 59.

such remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law.”¹³⁰ The Human Rights Committee has emphasized that states must ensure “accessible and effective remedies” for human rights violations and to take into account “the special vulnerability of certain categories of person,” and further noted that “a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant (ICCPR).”¹³¹

The right to a remedy in the context of the right to health is closely linked to accountability, which is a key element in ensuring the right to health and in the enjoyment of all human rights. The UN Special Rapporteur on the right to health has stated that “without accountability, human rights can become no more than window-dressing.”¹³² Accountability has been called the “raison d’être of a rights-based approach.”¹³³ It has two main components: redressing past grievances and correcting systemic failures. Accountability is not about blame and punishment, but it is a process that helps to identify what works so it can be repeated and what does not so it can be revised.¹³⁴ Where mistakes have been made, accountability requires redress.¹³⁵ It is also concerned with ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized for all, including disadvantaged individuals, communities, and populations.¹³⁶

¹³⁰ Maputo Protocol, art. 25(a).

¹³¹ UN Human Rights Committee, General Comment 31: Nature of the General Legal Obligation on States Parties to the Covenant, U.N. Doc. CCPR/C/21/Rev.1/Add/13 (2004), para. 15.

¹³² Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/7/11, January 31, 2008, <http://daccessdds.un.org/doc/UNDOC/GEN/Go8/105/03/PDF/Go810503.pdf?OpenElement> (accessed April 9, 2010), para.30.

¹³³ Office of the High Commissioner for Human Rights, “Claiming the Millennium Development Goals: A human rights approach,” 2008, www.ohchr.org/Documents/Publications/Claiming_MDGs_en.pdf (accessed September 28, 2009), p. 15.

¹³⁴ Human Rights Council, Report of the Special Rapporteur on the right to health, para. 99.

¹³⁵ Ibid.

¹³⁶ Ibid.

IV. Access to Health Information

Access to health information is a necessary part of women's and girls' ability to make informed choices and to access health services needed to ensure healthy pregnancy and delivery and treatment for related complications such as obstetric fistula.

Various information gaps noted in this report—concerning sexuality education, family planning, cost of care, government policies on fee exemptions and waivers, what fistula is, and availability of fistula repair services—show major shortcomings in the Kenyan government's obligations to ensure that the public has adequate health information. The government is aware of such gaps but has not taken deliberate and targeted measures to substantially reduce them.

The right to access health-related information translates into both negative and positive obligations on the part of the state. On the one hand, the state is obligated to refrain from limiting access to information and from providing erroneous information. On the other hand, it must ensure access to full and accurate information. Paragraph 34 of General Comment No. 14 of the Committee on Economic, Social and Cultural Rights calls upon states to “refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information.”

Sexuality Education

The risk of obstetric fistula often begins when young girls get pregnant or marry early, before their bodies are able to safely sustain a pregnancy. One of the factors leading to early pregnancy and childbearing is the lack of accurate reproductive health knowledge. We spoke to some girls who displayed a lack of basic knowledge on sexuality while others told us that they did not have this knowledge before becoming pregnant. Ten of the girls aged 18 years and below whom we interviewed told us they got pregnant from their first sexual encounter. Seven of them said they had unprotected sex but thought they would not get pregnant because it was their first time, two said it was because they had irregular menstrual periods, and the other because her boyfriend told her she would not fall pregnant. For example, 17-year-old Mueni M. who became pregnant in 2008 while in primary school told us, “I did not know I would get pregnant because it was the first time. I did not know

anything about condoms.”¹³⁷ She also told us that they had not received any sexuality education in school.¹³⁸ Kemunto S. also became pregnant while in primary school. She said, “I got pregnant when I was 16 years old. I was in standard seven and thought because my periods did not come every month I would not fall pregnant. I did not know anything about contraceptives although I had heard people talk about condoms.”¹³⁹

Unease surrounds the topic of sexuality education in Kenya, with some parents and religious leaders opposing the provision of such education because, they say, it would lead to promiscuity.¹⁴⁰ For example, a primary school teacher told Human Rights Watch, “Parents don’t want it [sexuality education] sometimes. They say children are taught how to be promiscuous. Another teacher was telling me the other day that parents in his school say we are teaching their children how to have sex.”¹⁴¹ Another teacher, Stella Kinaki said, “We have parents who say what we are teaching [sexuality education] is spoiling their children. Sometimes we go for meetings and some teachers are also not comfortable with some of the things we are supposed to teach.”¹⁴² Another one told us, “It is not just pupils who need sexuality education. Parents also need to be told why it is important.”¹⁴³

The government has made efforts to introduce life skills training, which includes sexuality education, in schools. In January 2008, the government asked upper primary and secondary schools to teach life skills and called for the provision of adolescent/youth-friendly

¹³⁷ Human Rights Watch interview with Mueni M., Machakos, December 6, 2009.

¹³⁸ Five other girls also told us they had not been taught about sexuality in primary school.

¹³⁹ Human Rights Watch interview with Kemunto S., Kisii, November 11, 2009.

¹⁴⁰ The director of Public health has been quoted saying that opposition from parents, religious groups and some civil society bodies had led to a “censored sex education campaign” in schools. Irin PlusNews, “Kenya: Back-street Abortions Underline Need for Sex education,” October 19, 2009, <http://www.plusnews.org/report.aspx?ReportId=86641> (accessed July 1, 2010). A study by the Centre for the Study of Adolescence—an NGO that has been conducting sexuality and HIV/AIDS education in primary and secondary schools in Kenya—looking at the implementation of the Ministry of Education’s Return to School Policy to enable girls who get pregnant return to school after delivery, criticizes the government for lack of comprehensive sexuality education in schools despite the government being aware of such a need. The study further says, “[o]pposition from religious and community leaders as well as policy and decision makers has often been a major barrier, preventing young people from accessing information and services, which would enable them meet their sexual and reproductive health needs.” Rosemarie Muganda-Onyando and Martin Omondi, “Down the Drain: Counting the Costs of Teenage Pregnancy and School Drop Out in Kenya,” 2008, <http://www.csakenya.org/pdfs/CSA%20Pregnancy-FINAL%202-EDITED.pdf> (accessed July 1, 2010), p. 31.

¹⁴¹ Human Rights Watch phone interview with Monica Kironcho, primary school teacher, June 25, 2010.

¹⁴² Human Rights Watch phone interview with Stella Kinaki, primary school teacher, June 25, 2010. Also see Scholastica Nganda, “Sex Education: Do Our Teens Need It?,” <http://www.arsrc.org/downloads/uhsss/nganda.pdf>, (accessed June 14, 2010), p. 7. Nganda notes, “The issue of sexuality education has become an exceptionally controversial one. The mere mention of sexuality education gives rise to many questions.”

¹⁴³ Human Rights Watch phone interview with James Kiprotich, high school teacher, June 25, 2010.

reproductive health services.¹⁴⁴ In 2009, the Ministry of Public Health and Sanitation and the Ministry of Education launched a National School Health Policy and implementation guidelines that address sexuality issues.¹⁴⁵ Experts say there are gaps in implementing this policy.¹⁴⁶ Teachers interviewed by Human Rights Watch told us that lack of time, because sexuality education is not part of the school syllabus and therefore not a priority subject, is the main hindrance to it being taught in schools.¹⁴⁷ A headmaster at a primary school told us, “We appreciate that this is an important issue for children to learn, but unless we make it part of the syllabus, time will always be a barrier.”¹⁴⁸

Family Planning Information

Family planning education, information, and services are critical to women’s wellbeing and to their reproductive and maternal health. Adequate information about the advantages of family planning and contraception methods, as well as access to such services, is important for reducing maternal deaths and morbidities such as obstetric fistula because it helps women to have planned pregnancies. According to the 2008-09 Kenya Demographic Health Survey, 43 percent of most recent births were not planned, underscoring the need for family planning education and services.¹⁴⁹

Our interviews show that access to accurate and comprehensive family planning information for some of the rural women and girls is a challenge. About half of the women we spoke to said they had no knowledge of family planning and contraception before they got pregnant and an equal number told us that they had learned more about family planning during antenatal care, and none of the women said they received family planning information from a community health worker. Misinformation is a problem as well as lack of information.

¹⁴⁴ See, National Council for Population and Development and Department of Reproductive Health, “Adolescent Reproductive Health Development Policy,” 2003; Ministry of Health, “National Guidelines for Provision of Youth-Friendly Services (YFS) in Kenya,” July 2005; Ministry of Public Health and Sanitation, “National School Health Policy,” 2009; and Division of Reproductive Health et al., “Adolescent Reproductive Health and Development Policy Plan of Action 2005-2015,” August 2005.

¹⁴⁵ Ministry of Public Health and Sanitation and Ministry of Education, “National School Health Policy,” and Ministry of Public Health and Sanitation and Ministry of Education, “National School Health Guidelines,” 2009.

¹⁴⁶ For example, Rosemary Muganda-Onyando, director of the Centre for the Study of Adolescence commented, “teachers are not well-informed to provide sexuality education, besides there are no detailed guidelines provided.” Muthoni Ndungu, coordinator of the Reproductive Health and Rights Alliance also noted “The subject [sexuality education] is not examinable so it’s up to the teacher to plan when to teach. There is no accountability to ensure teachers are actually teaching.”¹⁴⁶ Human Rights Watch interviews with Rosemarie Muganda-Onyando, Nairobi, December 2, 2009, and Muthoni Ndungu, Nairobi, December 3, 2009.

¹⁴⁷ Human Rights Watch phone interview with Monica Kironcho, June 25, 2010.

¹⁴⁸ Human Rights Watch phone interview with Kirimi Njue, secondary school teacher, June 25, 2010.

¹⁴⁹ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p.xix.

Seventeen-year-old Monica J. told us, “My boyfriend told me the withdrawal method was best for us because we were not married. I don’t know about any other method.”¹⁵⁰

Our research shows that there is need to take deliberate steps to educate rural, young, and illiterate women about the importance of family planning and the available methods. The government is aware of the information deficit among poor, rural, and uneducated women.¹⁵¹

The Community Strategy provides an opportunity to reach rural women with family planning information. One of the activities in the Community Strategy is provision of family planning information and services. Community health and extension workers are required to create awareness on the importance of family planning and services available, but none of the women and girls we interviewed had received such information from these workers. Current available data from the 2008-09 KDHS indicates that a mere 5 percent of women who are not using any family planning method are being reached by field workers to discuss family planning issues, and only 9 percent who visited health facilities in the 12 months before the survey discussed issues of family planning with the health facility staff. This implies that many opportunities are lost to educate potential users on the benefits of family planning.¹⁵²

Fistula repair camps also present an opportunity to talk to women and girls about family planning, but this does not always happen. Three nurses, out of the five we interviewed working in fistula wards, told us that they do not talk to women about family planning. For example, one of the nurses, a trainer on post-operative care for fistula patients, said, “We do not give them [women and girls] any information on family planning because we do not allow for sexual activity before six months; we tell them to abstain. Also, many do not have children.”¹⁵³ A nurse at Jamaa Hospital told us that their policy—they are a Catholic mission

¹⁵⁰ Human Rights Watch interview with Monica J., Kisumu, December 9, 2009.

¹⁵¹ The 2008-09 KDHS indicates although that there is widespread awareness about different methods of family planning, “Exceptions are found among women with no education, women in the lowest wealth quintile, and women in North Eastern province, where less than half of married women have heard of any method. It further notes: “There is a sharp contrast between urban and rural areas in exposure to family planning messages through television and print media. For example, 64 percent of women and 60 percent of men in urban areas are exposed to family planning messages through television, compared with only 29 percent of women and 31 percent of men in rural areas.” KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, pp. 58 and 72.

¹⁵² *Ibid.*, p. 75.

¹⁵³ Human Rights Watch interview with Christine Muthengi, fistula care trainer, Kenyatta National Hospital, Kisii, November 11, 2009.

hospital—does not allow them to talk to women about family planning.¹⁵⁴ This assertion was confirmed by the hospital administrator.¹⁵⁵

Under the focused antenatal care program, women and girls should be given post-partum family planning information,¹⁵⁶ which is important for making decisions about the healthy spacing of pregnancies, the mother’s risk of unintended pregnancy after birth, and specific methods of post-partum family planning such as lactational amenorrhea. A study by Population Council found that providers failed to provide this information consistently.¹⁵⁷ In addition, post-natal care attendance is very low in Kenya, further limiting opportunities for provision of family planning information. The current Demographic and Health Survey shows that 53 percent of women did not receive postnatal care for their most recent birth, particularly poor, illiterate, and rural women.¹⁵⁸

Information on the Need for Facility Deliveries

As noted earlier, a key government priority in improving maternal health is increasing access to skilled attendance during pregnancy, delivery, and after delivery. Women and girls should be told about the importance of facility delivery during antenatal care visits and in communities through community health and extension workers, but this is not always the case. Although only ten women out of the 40 we interviewed who said they attended antenatal care said they were not given this information, there is need to ensure that all women understand the importance of delivering in a medical facility.

Gaps also exist in giving women information about potential complications during childbirth, as discussed in more detail below. It is important that at antenatal care women are told

¹⁵⁴ Human Rights Watch interview with Bridget Mbwika, nurse at the fistula ward, Jamaa Mission hospital, Nairobi, December 2, 2009.

¹⁵⁵ Human Rights Watch interview with George Audi, hospital administrator, Jamaa Mission Hospital, Nairobi, December 2, 2009.

¹⁵⁶ Population Council, “Acceptability and Sustainability of the WHO Focused Antenatal Care package in Kenya,” 2006, http://www.whiteribbonalliance.org/Resources/Documents/Acceptability%20and%20Sustainability%20of%20WHO%20FANC%20in%20Kenya_USAID.pdf (accessed April 9, 2010), p. 34. Focused antenatal care (FANC) is an approach to antenatal care that emphasizes a comprehensive approach to pregnancy and childbirth through early detection and treatment of problems and complications through prevention of complications and disease, birth preparedness and complication readiness, and health promotion. FANC is individual woman-centered and a skilled health provider should attend to the women. See Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (accessed March 31, 2010), “Focused Antenatal Care: Providing Integrated, Individualized Care During Pregnancy,” http://www.accessstohealth.org/toolres/pdfs/ACCESSstechbrief_FANC.pdf (accessed May 3, 2010).

¹⁵⁷ Ibid.

¹⁵⁸ KNBS and ICF Macro, *The Kenya Demographic and Health Survey 2008-09*, p. 123.

about possible complications that could arise, and that these can happen with any pregnancy. We spoke to four women who said they delivered at home because they had had prior uncomplicated births at home. One told us, “I had four deliveries at home and they were very easy and I normally deliver after a very short while after experiencing labor. I delivered with assistance from my husband's grandmother but this time I don't know what went wrong.”¹⁵⁹

Over half of all births in Kenya are categorized as high risk births, that is, births to women with three births or more, to those older than 34 years, or to those younger than 18 years.¹⁶⁰ These statistics underscore the need for the government to scale up information to women and communities on the value of women giving birth in health facilities. Additionally, it is important for the government to monitor the kind of information that women are given during antenatal care. Human Rights Watch interviews with nine nurses, three from dispensaries and six from hospitals, revealed that there were no oversight mechanisms at their facilities to ensure that health providers are giving women the required information during antenatal and postnatal visits.

Information on What Fistula Is and Treatment Availability

Almost all the women and girls we interviewed had never heard about fistula before they developed it, and many were surprised to come to the hospital and meet so many women seeking fistula treatment.¹⁶¹ They had thought they were the only ones.

Misinformation about fistula abounds, contributing to delays in seeking treatment. Some women thought that incontinence was normal after delivery,¹⁶² that they got fistula after Cesarean sections,¹⁶³ or that the bladder cannot be repaired.¹⁶⁴ An HIV positive woman told

¹⁵⁹ Human Rights Watch interview with Nyakiriro C., Kisii, November 11, 2009.

¹⁶⁰ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 110.

¹⁶¹ Human Rights Watch interviewed women who had lived with fistula for various lengths of time: 45 years to one month.

¹⁶² One woman told us “I thought it is something that happens when one gives birth,” and another, “I waited for two months before going to Wote [health facility] because I thought the problem would go away.” A nurse told us, “Many of the women and girls I have interacted with during this camp and the camp in October think it [fistula] is a ‘natural outcome of delivery.’” Human Rights Watch interviews with Nduku K., Machakos, December 6, 2009; Mueni M., Machakos, December 6, 2009; and Lilian Ndege, nursing officer in charge of the gynecology ward, Kisii General Hospital, Kisii, November 11, 2009.

¹⁶³ Almost a quarter of the women and girls interviewed by Human Rights Watch said this.

¹⁶⁴ When researchers asked Fatuma H. why she had not sought treatment for fistula she told us, “I didn't know that a bladder can be repaired.” Nekesa U. told us that she had a difficult time convincing her husband to take her to the fistula camp for surgery: “People told my husband ... ‘that woman cannot heal because there is no way you can stitch the bladder. It's a lie.

us people in her community say she got fistula because she is HIV positive and she believes that because HIV cannot be cured, fistula too cannot.¹⁶⁵

Some TBAs and religious leaders perpetuate these myths by giving wrong information to women who seek their help. Nyakundi B. lived with fistula for four years because when she told her mother about her condition,

My mum took me to a traditional healer who told her that the doctors left cotton inside me and that's why I had the problem. They told her they would pray for me and I should go to their church. I went many times and they prayed but nothing happened so I stopped. I just stayed at home until I heard about the camp on radio.¹⁶⁶

Over half of the women and girls we interviewed informed us that no one explained fistula in health facilities where they delivered or when they sought fistula treatment.¹⁶⁷ Six of the nurses we interviewed said they did not talk to women about fistula or incontinence during antenatal or postnatal care visits.¹⁶⁸ All of them said they lacked the time to talk to women about a range of important issues because of capacity. A nurse at Kisii General Hospital told us,

It is true that we do not talk about fistula to patients and that it is not integrated in the health talks. It is a big gap. But the hospital is busy and staffing is limited. Maybe you are one nurse with many people waiting. You feel like you want to give the most basic information. Work is always

They want to eat your money.” Human Rights Watch interviews with Fatuma H., Kisumu, December 9, 2009, and Nekesa U., Kisumu, December 9, 2009.

¹⁶⁵ Human Rights Watch interview with Cherono S., Kisumu, December 7, 2009.

¹⁶⁶ Human Rights Watch interview with Nyakundi B., Kisii, November 10, 2009.

¹⁶⁷ For example, Beatrice N. told us, “When I was leaving the hospital the water [urine] was coming out but the doctor didn’t tell me what it was. He just told me to go and buy medicine and come back after four months.” Wairimu K. remarked, “I stayed in the hospital for two weeks after giving birth but I was not told what my illness was.” Human Rights Watch interviews with Beatrice N., Kisii, November 11, 2009, and Wairimu K., Kisumu, December 9, 2009.

¹⁶⁸ Nurses are required to talk to patients about potential complications during FANC. An evaluation by Population Council found that clients do not receive all the required information and that “Providers consistently provided selective information, thus undermining the comprehensiveness of focused ANC. Population Council, “Acceptability and Sustainability of the WHO Focused Antenatal Care package in Kenya,” p. 32. The 2004 Kenya fistula needs assessment report also notes that health providers do not talk about obstetric fistula during health talks in hospitals. Ministry of Health and UNFPA, “Needs Assessment of Obstetric Fistula in Kenya,” p.20.

overwhelming. There is no time to give them all the information they should get at focused antenatal care and time for them to ask questions.¹⁶⁹

A number of the nurses and doctors we spoke to observed that some health providers also lack the necessary information about fistula to educate women.¹⁷⁰

Lack of information on fistula among some healthcare providers hinders appropriate and timely referrals and adds to women's and girls' suffering. We spoke to women who said they were asked to keep going to hospital without any explanation of what the problem was and what treatment they would be getting or if they would get better. Mueni M.'s case is an example. She told us "I went home and realized water [urine] was coming out. I went back to Wote and asked them 'what is wrong' and they just said I be going to clinic. I went back three times and saw it wasn't helping and so I stopped going."¹⁷¹ Another woman told us,

I developed the problem when I was in hospital. They put a tube in me but it did not help. They said I go home and gave me a return date. I went home and the problem got worse. I returned to the hospital but they said I wait for the appointment day. I went back home and returned on the appointment date. They checked and gave me medicine and told me to come after one month. The tablets didn't help but I came back after one month. They gave me another day to come back. This continued three times and I got tired and I stopped coming.¹⁷²

The situation can be particularly bad when health providers fail to give correct information. Kemunto S. got fistula when she was 16 years old. The doctor at Kisii General Hospital (a level 4 facility then) where she delivered told her, "[G]o home ... eat and get fat. [T]he problem will end." She told us, "I stayed at home for one month but the problem was getting

¹⁶⁹ Human Rights Watch interview with Lilian Ndege, nursing officer in charge of the gynecology ward, Kisii General Hospital, Kisii, November 11, 2009.

¹⁷⁰ The 2004 Kenya Service Provision Assessment Survey found that medical providers were lacking in knowledge not only about new methods, but also about basic information critical to providing quality maternal health care. For example, only 6 percent of midwives interviewed for the survey could name all four categories of the signs of postpartum hemorrhage and only 12 percent of midwives were able to name all four expected interventions for postpartum hemorrhage, while guidelines for managing delivery complications were available in only 7 percent of facilities. NCAPD et al., "Kenya Service Provision Assessment Survey 2004," p. 132. Moreover, in fewer than one-third of facilities had the majority of providers received any structured training relating to delivery services during the past year, and only 8 percent of providers had received routine training on life-saving skills. *Ibid.*, pp. 144-45.

¹⁷¹ Human Rights Watch interview with Mueni M., Machakos, December 6, 2009.

¹⁷² Human Rights Watch interview with Nyakundi B., Kisii, November 10, 2009.

worse. I came back and they said just go home and eat. They told me to eat soft food and vegetables because these would help in natural repair. I went home, ate them but nothing happened; the urine and stool were coming out.¹⁷³ Kemunto S. was highly stigmatized by her family and community, and developed mental problems. In 2002, after living with fistula for 10 years and enduring physical violence from her husband, she convinced her husband that they should seek treatment. However, he got frustrated with the back and forth journeys to the hospital, told her to stop treatment, and eventually chased her away. She narrated her story to Human Rights Watch:

In 2002 my husband looked for money and we went back to Kisii General. The doctor examined me and told me to come back after one month. I came back but they said the doctor was not around. They told me to take two weeks and return. I returned after two weeks and they said I needed to be examined in the lab. The lab said I go to Dr. Kasioki [not his real name] to get the results. I went to him. He didn't tell me anything. He said go and come another day. My husband got annoyed, he was frustrated and asked me to stop going to hospital but I convinced him that we try once more. We returned after two weeks. I went to Dr Kasioki. He just looked at me and said he couldn't help me. He told my husband I couldn't become pregnant. My husband said I had miscarried but the doctor insisted I can't conceive or be cured. My husband got annoyed. He said to me, when we go home, I want you to take your clothes and leave and go back to your parents because you cannot fall pregnant.¹⁷⁴

Many women and girls do not seek fistula surgery because they do not know that these services are available. There is little or no mobilization done except for announcements about free repair camps. Dr. Mitei, a fistula surgeon at Kisumu Provincial General Hospital told us, "Patients don't just come; they come during camps when there is good mobilization unless they are referred by other patients, which is very rare."¹⁷⁵ The Freedom from Fistula Foundation is the only organization doing routine mobilization, but even so, they say they

¹⁷³ Human Rights Watch interview with Kemunto S., Kisii, November 11, 2009.

¹⁷⁴ Ibid.

¹⁷⁵ Human Rights Watch interview with Dr. Paul Mitei, fistula surgeon, Kisumu Provincial General Hospital, Nairobi, November 26, 2009.

are limited by capacity. The organization has hotlines that women can call for referral to Jamaa Mission Hospital.¹⁷⁶

In 2004, the Division of Reproductive Health in what was the Ministry of Health and UNFPA conducted a fistula needs assessment in Kenya that showed lack of awareness about fistula in communities as a barrier to its prevention and treatment. Seven years later, the problem persists, and the government has done little to address this barrier by providing accurate information about the causes of fistula in communities.

Information about fistula and the availability of treatment is mainly done before fistula camps, which involve mobilization, screening of women for obstetric fistula, and repair surgery for those affected. Often, the information is targeted towards communities in the region where the camps will be held. This leaves out regions where fistula camps have never been held. The government needs to conduct a country-wide information campaign about fistula through the mass media, and through other avenues such as churches, community health workers, and provincial administrators who work with rural communities.

The government has a key role to play in ensuring women have access to accurate and up to date information about fistula to ensure that it is meeting its obligations to correct persistent myths and misinformation about fistula in the communities. The Kenya government should take measures to ensure that health providers have knowledge about fistula and that they give this information to women and girls during antenatal and postnatal care visits. It can do this by integrating information about fistula into in-service training for health providers.

¹⁷⁶ Human Rights Watch Interview with Amy Irving, Program Officer, Freedom from Fistula Foundation, Nairobi, December 3, 2009.

V. Availability and Accessibility of Services

An equitable, well-resourced, accessible (physically and financially) and integrated health system is widely accepted as being a vital context for guaranteeing women's access to the interventions that can prevent or treat the causes of maternal deaths and injuries such as obstetric fistula.¹⁷⁷

Kenya has taken many positive steps to advance women's and girls' maternal and reproductive health. These initiatives include eliminating charges for public family planning services, antenatal and postnatal care, and prevention of mother-to-child HIV transmission. The government has also eliminated charges for delivery in dispensaries and health centers to encourage women to deliver in medical facilities with a skilled birth attendant. In addition, by introducing a system of full or partial fee waiver for access to government hospitals, the government has taken steps to increase access to health care for indigent patients. However, slow and sometimes absent progress in certain key areas calls into question whether Kenya is living up to its obligation with respect to the right to health. Many of the problems affecting the health sector in Kenya have persisted for many years. They include shortage of medical staff, mal-distribution of available staff and health facilities to the disadvantage of rural and poor regions, frequent shortages of supplies including family planning supplies, and failure to ensure health services are accessible to the poor.

Family Planning

Family planning is recognized by experts as key in reducing maternal mortality, improving women's general wellbeing and accelerating progress toward achieving the Millennium Development Goals. For example, family planning can reduce the number of times a woman becomes pregnant. Generally speaking, women who have had three births or more face greater risks in pregnancy. Family planning reduces the number of unintended and unwanted pregnancies, which are far more likely to end in induced abortions, and are far less likely to receive adequate prenatal care than planned pregnancies. In addition, family planning can be targeted to reduce the number of pregnancies to women in groups at

¹⁷⁷ UN General Assembly, "Note by the Secretary-General: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health," 13 September 2006, A/61/338, para. 14. It states, "While the right to health includes entitlements to specific health-related goods, services and facilities, it should also be understood more broadly as an entitlement to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."

increased risk of maternal death, such as women who are too young or older, and women who have had more than five previous births.¹⁷⁸

Women and girls in Kenya face a number of obstacles in accessing family planning, one being lack of sufficient facilities offering a wide variety of family planning methods. Current available data indicates that “the proportion of health facilities offering any temporary modern methods of family planning declined to 75 percent in 2004 from 88 percent in 1999.”¹⁷⁹

Another challenge is contraceptive stocks. The family planning findings of the Kenya Service Provision Assessment Survey found that as of 2004 (more recent data is not available), “19 percent [of facilities] providing combined oral contraceptives and 18 percent of facilities providing progestin-only injectables reported a stock out sometime in the six months before the survey.”¹⁸⁰

In August 2009, media reports revealed that contraceptives were largely out of stock across the country. For example, Muraguri Muchira, the director of programs at Family Health Options Kenya, one of the largest providers of family planning in the country, was quoted saying that injectables, one the most common methods of contraception in Kenya, were not readily available then: “We don’t have enough of them in the government supplies or even the Non Governmental Organisations. In our (Family Health Options) case, we are sometimes forced to buy from the private sector which is very expensive and we can’t afford to buy enough quantities to meet the demands.”¹⁸¹ According to Muchira, “The biggest challenge we have as a country is the sourcing of contraceptives. Kenya depends highly on development partners and each one of them brings their supplies in their own different

¹⁷⁸ See Family Health International, “The Importance of Family Planning in Reducing Maternal Mortality,” undated, <http://www.fhi.org/en/RH/Pubs/Briefs/MCH/factsheet11.htm> (accessed May 20, 2010). A study conducted by the Guttmacher Institute and UNFPA estimated that if countries invested in family planning, unintended pregnancies would drop by more than two thirds, 70 percent of maternal deaths would be averted (a decline from 550,000 to 160,000), 44 percent of newborn deaths would be averted (a decline from 3.5 million to 1.9 million), unsafe abortions would decline by 73 percent (from 20 million to 5.5 million, assuming no change in abortion laws), and the healthy years of life lost due to disability and premature death among women and their newborns would be reduced by more than 60 percent. S. Singh et al., *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health* (New York: Guttmacher Institute and United Nations Population Fund, 2009), p. 4.

¹⁷⁹ NCAPD et al., Kenya Service Provision Assessment Survey 2004,” p. 95. Overall, health facilities are few and inequitable distributed.

¹⁸⁰ NCAPD et al., “Kenya Service Provision Assessment Survey 2004: Family Planning Key Findings,” p. 5.

¹⁸¹ Catherine Karongo, “Kenya Reports Shortage of Contraceptives,” <http://www.capitalfm.co.ke/news/Local/Kenya-reports-shortage-of-contraceptives-5372.html>, Capital FM, August 2009, (accessed March 29, 2010).

channels. So it's very difficult to know how much is being brought in the country at any one time. And as far as I know nobody has come up with a solution.”¹⁸²

In Kenya, as elsewhere in sub-Saharan Africa, the past decade has seen a weakening prioritization of contraceptive programs, undermining access to services.¹⁸³ An analysis of the 2009/2010 Kenyan budget by Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation, GTZ) indicated that, “Against the general trend, the allocation for Family Planning, Maternal and Child Health is declining by 15%. Only 1.8% of the overall government expenditures on health are spent on this issue.... This is clearly contradictory to policy objectives.”¹⁸⁴

Human Resource Constraints

The availability, quality, comprehensiveness, and utilization of health services, including maternity services, offered at a health facility depend, in large part, on the number of health workers at that facility. The Kenyan health sector suffers from longstanding human resource shortages, especially in rural areas.¹⁸⁵ According to the Human Resource for Health Strategic Plan, “there are overall staff shortages (47,247 staff against an estimated minimum requirement of about 72,234). Shortfalls are heavily concentrated in parts of Coast, North Eastern Rift Valley and Nyanza Provinces, areas that have the lowest health indicators.”¹⁸⁶ The two health ministries note that “government personnel remain heavily skewed in favour of hospitals and the better-off districts.”¹⁸⁷ Hospitals and high-level facilities have more qualified staff.¹⁸⁸

In 2005, it was estimated that “[d]ispensaries have a median of one enrolled midwife while health centers have a median of one enrolled nurse and one enrolled midwife. Hospitals

¹⁸² Ibid.

¹⁸³ See WHO et al., *The Millennium Development Goals Report*, p. 38.

¹⁸⁴ GTZ Health Sector Programme Kenya, “Estimated Government Spending 2009/2010: Kenyan Health Sector Budget Analysis,” undated, http://www.hdwg-kenya.com/new/index.php?option=com_docman&task=doc_download&gid=889&Itemid=141 (accessed May 3, 2010).

¹⁸⁵ For example see, Joyce Mulama, “One Nurse, One Dispensary, 9,000 Patients,” *Saturday Nation*, July 3, 2010. In this article, the author visited a dispensary in Turkana, a rural and poor region in Northern Kenya. It quotes the only medical staff at the facility saying, “I am everything in this [dispensary]. I do the clerking, examination of patients, dispensing drugs, stitching cuts, antenatal care and even delivery [of] babies.”

¹⁸⁶ Ministry of Public Health and Sanitation and the Ministry of Medical Services, “Health Care Financing Policy and Strategy: Systems Change for Universal Coverage,” November 2009, p.6.

¹⁸⁷ Ibid.

¹⁸⁸ Ibid.

have a median of three doctors.”¹⁸⁹ Two of the dispensaries we visited in Machakos and Kisumu had only one nurse attending to all categories of patients. When we arrived at the dispensary in Machakos, there was a long queue of men and women with children waiting to be attended to by the one nurse, who informed us that she was late because she had to purchase some supplies. At the Machakos General Hospital, a nurse in the gynecology ward had to ask a nurse from another ward to assist in giving patients medicine because she was alone in ward of about forty patients, and she was not able to attend to all of them in a timely manner.

Another challenge is that health facilities serve very large populations: “The median population in a hospital catchment area is more than 100,000, while dispensaries, which have limited staff, serve a catchment population of around 8,000.”¹⁹⁰ Many of the doctors, nurses and experts we interviewed reiterated this concern. There are also problems with retaining staff in hard-to-reach and rural areas.

In order to make substantial progress in reducing maternal mortality and morbidity, the Kenyan government should be developing and implementing a plan that aims to ensure that there is a sufficient quantity of qualified health workers available, whose services can be provided in a fair and equitable distribution throughout the country.

Poor Access to Emergency Obstetric Care

Another critical problem that women face in accessing maternal health services, and thus avoiding fistula, is lack of adequate facilities offering delivery and emergency services. Only about 38 percent of facilities offer normal delivery services. Hospitals, which are usually located in urban and peri-urban areas, offer most of these services.¹⁹¹ Facility-based 24-hour delivery services are available in 64 percent of health centers in the country.¹⁹²

Many women in Kenya have poor access to emergency obstetric care that could save both their lives and prevent stillbirths in case of complications during pregnancy or childbirth.

¹⁸⁹ Ibid.

¹⁹⁰ NCAPD et al., “Kenya Service Provision Assessment Survey 2004,” p. 30. It is possible that the catchment areas of government and nongovernment facilities overlap, since government catchment areas are constructed to serve the entire population, whereas nongovernmental facilities define their own catchment areas, usually without coordinating with the government. However, the problem of facilities being overstretched remains.

¹⁹¹ Ibid., p.128. The survey noted that the percentage of facilities offering normal delivery services in 2004 remained relatively similar to that observed in 1999.

¹⁹² Ibid., p. 35.

Women with obstructed labor, which can lead to fistula, need emergency obstetric care such as Cesarean sections.¹⁹³ The 2004 Kenya Service Provision Assessment Survey concluded that capacity to manage common or serious complications of labor and delivery is weak in all facilities, including hospitals.¹⁹⁴ Less than 10 percent of medical facilities in the country were able to offer basic emergency obstetric care as of 2004.¹⁹⁵ The national coverage rate for basic emergency obstetric care was 2.7 per 500,000 population (well below the recommended level of four per 500,000 population) in most provinces.¹⁹⁶ Only six percent of medical facilities can provide comprehensive emergency obstetric care.¹⁹⁷

Poor Transport and Referral System for Women and Girls in Labor

Transport availability and poor road infrastructure influence the ability of pregnant women, especially those in rural areas, to deliver in health facilities and to access emergency obstetric services.¹⁹⁸ Jessica Momanyi, nursing officer in charge of reproductive health at Kisii General Hospital, told us: “We see many cases that come here and they are too late. They delay too much at the community level because of transport issues.”¹⁹⁹ Transport is a major problem at night. Some women told us about having to walk long distances while in

¹⁹³ The World Bank has estimated that if all women had access to emergency obstetric care, 74 percent of maternal deaths could be averted. Millennium Project, Task Force on Child Health and Maternal Health, *Who's Got the Power?*, p. 5.

¹⁹⁴ NCAPD et al., “Kenya Service Provision Assessment Survey 2004,” p. 139.

¹⁹⁵ *Ibid.*, p. 148.

¹⁹⁶ *Ibid.* The overall coverage for comprehensive emergency obstetric care is nearly two facilities per 500,000 population, but wide regional differentials exist. At the time the KSPAS was done, the recommendation for the mixture of basic and comprehensive emergency obstetric care facilities per 500,000 population was at least one comprehensive and four basic emergency obstetric care facilities per 500,000 population. This has been revised to at least five emergency obstetric care facilities including at least one comprehensive facility per 500,000 population. See, WHO et al., *Monitoring Emergency Obstetric Care: A Handbook*, (Geneva, WHO Press, 2009), p. 5.

¹⁹⁷ NCAPD et al., “Kenya Service Provision Assessment Survey 2004,” pp. 146-147. Emergency obstetric care involves a set of services or interventions called “signal functions” that should be available in a facility that provides emergency care for women with pregnancy-related complications. These “signal functions” are proven to significantly reduce maternal deaths and improve birth outcomes for the newborn, and they must be performed at a facility in order for that facility to be recognized as an emergency obstetric care facility. A facility can either be classified as a basic emergency obstetric care or a comprehensive emergency obstetric care facility. The basic emergency obstetric care signal functions are seven and include: administration of parenteral antibiotics, oxytocic drugs (drugs that expand the cervix or vagina to facilitate delivery), and anticonvulsants; manual removal of placenta; manual vacuum aspiration of retained products of conception; assisted vaginal delivery, and basic neonatal resuscitation. Comprehensive emergency obstetric care includes the seven basic signal functions, plus performing surgery (for example, cesarean section), and blood transfusion. See WHO et al., *Monitoring Emergency Obstetric Care: A Handbook* (Geneva: WHO Press, 2009). The earlier guidelines did not include basic neonatal resuscitation in the basic services category. In addition, the name of the second signal function has been changed from “administer parenteral oxytocics” to “administer uterotonic drugs.” *Ibid.*, pp. 6-7. At the time the service provision assessment survey was done, the earlier, 1997, guidelines were in use.

¹⁹⁸ According to the 2008-09 KDHS, 43 percent of rural women say they did not deliver in a health facility because it is too far or due to lack of transport. KNBS and ICF Macro, Kenya Demographic and Health Survey 2008-09, p., 121.

¹⁹⁹ Human Rights Watch interview with Jessica Momanyi, nursing officer in charge of reproductive health, Kisii General Hospital, Kisii, November 11, 2009.

labor to get to the nearest health facility and others said distance to facilities and lack of transport forced them to deliver under TBAs. More than half of fistula patients we interviewed cited transport problems.

Poor access to transport contributes to fistula

“I began labor at 7 p.m. and I said I will go to the hospital in the morning. However, at around 2 a.m., the pain became so severe and the baby was coming fast. My husband tried to get a vehicle but we didn’t get one. My mother-in-law called some old women to help me. We went to the hospital the following morning and arrived at 9 a.m. The nurse said the baby was not breathing. I had a stillbirth. When I went back home I realized water was just coming out. Later I realized it was urine coming out.”

–Human Rights Watch interview with Jerotich N., Kisumu, December 9, 2009.

“I started labor about 2 p.m. My mum left and came back with an old woman who started examining me. The old woman she said the way of the baby was okay and I would deliver well. At 3 a.m, I had not delivered and my mum told her we should go to the hospital because I was in so much pain. However, we couldn’t get a vehicle at 3 a.m. so we waited until morning. My mother also realized she did not have money, and she had to borrow some from relatives. When we got to the dispensary the following day later in the afternoon, the nurse said we had delayed at home and the baby was dead. They took me to hospital and removed the baby. Then I developed this problem [fistula].”

–Human Rights Watch interview with Mueni M., Machakos, December 6, 2009.

“I felt some pains early in the morning. I went about doing my home chores. By evening, the pains were still mild so I went to bed. Around 1 a.m. the pain became so severe but we had to wait till morning to go to the dispensary because it was raining and the road was bad. We also couldn’t get a vehicle at night.”

–Human Rights Watch interview with Awino V., Kisumu, December 9, 2009.

Lack of transport between health facilities is common, and interferes with referrals for emergency obstetric care in higher level facilities. Many health facilities, particularly dispensaries and health centers, do not have ambulances.²⁰⁰ Even in cases where there are ambulances, there are other problems such as lack of fuel. Beatrice N. started labor at 3 a.m.

²⁰⁰ The KSPAS noted that only 27 percent of all facilities—and barely half of facilities specifically offering delivery services—have the ability to provide emergency transportation to another facility for obstetric emergencies. NCAPD et al., “Kenya Service Provision Assessment Survey 2004,” p. 130. Even when a facility does not offer delivery services, but does offer antenatal care, it is desirable to have emergency transport available because in most cases, especially in the rural areas, the facility where a woman receives antenatal care may be the nearest formal health sector site from which emergency help can be sought.

and quickly went to the nearest dispensary. They told her she would deliver at noon, which did not happen. At 6 p.m. they told her mother to take her to Kisii General Hospital. She said, “They said their car did not have fuel. We hired a car.”²⁰¹ Other times, there is delay at the referral facility. A nurse at Rabuor dispensary in Kisumu told us, “Sometimes you call the district hospital and they delay. I had a woman who had serious problems and they took over four hours to arrive.”²⁰² A nurse at a district hospital remarked, “Fuel is a challenge. I have heard the drivers say on several occasions that there is no fuel when dispensaries call for patients. This leads to delay in women getting help.”²⁰³ A doctor also noted, “Unless we give attention to dispensaries and health centers [by equipping them with ambulances], women will continue to get fistula.”²⁰⁴

The Kenyan government is in the process of finalizing a referral strategy that aims to improve communication and transportation between lower level and higher level referral health facilities through purchase and distribution of ambulances, and “To develop service providers’ capacity to offer services and appropriately refer at each level of the healthcare system.”²⁰⁵ The government should prioritize the completion of this policy as well its implementation, with a focus on rural and marginalized regions. In addition, the government should also prioritize implementation of the referral component of the community strategy, which would empower communities and families to prepare for obstetric emergencies.²⁰⁶

Facility and Staffing Challenges for Fistula Repairs

Efforts to address fistula in Kenya are largely focused on training surgeons to provide repair surgeries. In spite of ongoing efforts, lack of trained fistula surgeons remains a major challenge to addressing fistula in Kenya. Obstetric fistula is not a key area of gynecological training; doctors do not come out of university as competent fistula surgeons. Countrywide, there are about ten trained fistula surgeons and only four (one of whom is a retired private

²⁰¹ Human Rights Watch interview with Beatrice N., Kisii, November 10, 2009.

²⁰² Human Rights Watch interview with Maureen Odhiambo, Nurse in Charge, Railways Dispensary, Kisumu, December 9, 2009.

²⁰³ Human Rights Watch interview with Lilian Ndege, nursing officer in charge of the gynecology ward, Kisii General Hospital, Kisii, November 11, 2009.

²⁰⁴ Human Rights Watch interview with Dr. Stephen Mutiso, gynecologist and fistula surgeon, Machakos General Hospital, Nairobi, November 26, 2009.

²⁰⁵ Ministry of Public Health and Sanitation and Ministry of Medical Services, “Referral Strategy and Investment Plan for Health Services,” July 2008-June 2012, p. 22.

²⁰⁶ Ministry of Health, “Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level,” p. 34.

consultant) are considered experts able to handle complicated cases and to train others. Three of the experts are based in Nairobi and only occasionally travel to provincial or district hospitals during camps to assist in surgery and to train other doctors. Many people interviewed by Human Rights Watch said there is a general lack of interest in fistula training among doctors because the specialty brings little monetary gain.²⁰⁷

In addition, there are few hospitals equipped to handle the surgeries. Those that exist often lack equipment and supplies necessary for fistula repair. Availability of operating theater facilities is a common problem. Because fistula surgery is not considered an emergency, it is not prioritized. Dr Paul Mitei, a fistula surgeon at Kisumu Provincial General Hospital told us, “To do this work in a public hospital is not easy because there are many competing interests.... You may find there is no anesthetist, no theater table. On the day you have your elective [fistula surgery] if there are emergencies ... you just put off.”²⁰⁸

Routine fistula surgery is rare. Although a number of hospitals have the capacity to offer routine repairs, countrywide, fistula surgery is mainly done routinely in only three facilities: Kenyatta National Hospital (KNH) in collaboration with the Africa Medical Research Foundation (AMREF), Moi Referral and Teaching Hospital (national level public facilities) and at Jamaa Hospital, a mission facility. KNH and Jamaa are both based in Nairobi, even though most women needing surgery are from rural areas, far away from Nairobi.

Repair surgeries are done mainly through fistula camps, which are chiefly meant to be training camps on fistula repair and management for a mixed skill team of doctors, nurses, physiotherapists, anesthetists, and other medical support staff.²⁰⁹ Trained surgeons (mainly gynecologists) are then supposed to begin routine fistula surgery, but this hardly happens. However, many doctors, NGO representatives, and government officials we spoke to acknowledged that while fistula camps are good for training, they are not sustainable in the

²⁰⁷ Almost all the doctors we interviewed told us fistula is a disease of the poor and therefore one cannot make money from being a fistula surgeon. Most doctors in Kenya operate private clinics; most fistula survivors cannot afford the high charges.

²⁰⁸ Human Rights Watch Interview with Dr. Paul Mitei, fistula surgeon, Kisumu Provincial General Hospital, Kisumu, November 27, 2009.

²⁰⁹ UNFPA, through the global Campaign to End Fistula, funds the Kenya government for fistula repair camps in selected district and provincial hospitals. Each of the hospitals holds one camp per year. In addition to the fistula clinic they support at KNH, AMREF also provides financial support for fistula camps at selected district and provincial hospitals. Both AMREF and UNFPA also provide supplies and equipment for fistula surgery to hospitals. Other organizations that support fistula repair work include the Freedom from Fistula Foundation, the Safaricom Foundation, MSF Spain, and Women and Health Alliance International.

long run nor are they the best way of ensuring all women and girls living with fistula get timely treatment.²¹⁰

One of the reasons why fistula surgeons do not offer routine surgery includes lack of long-term mentoring. Some of the doctors we interviewed felt that the once a year training they received was inadequate and others added that this problem is compounded by the lack of continued support following the training to further improve their skills. According to the WHO, “A continuous partnership between the trainees and the trainers is important in maintaining and improving skills, and in acquiring new skills.”²¹¹ Dr. Khisa Wakasiaka, a fistula surgeon and trainer working with AMREF, told Human Rights Watch: “Mentoring and monitoring those surgeons who are trained is a challenge. It’s difficult to follow up on them to find out how they are doing and help them to further develop their skills.”²¹²

Women normally have to travel long distances to reach the few facilities that conduct fistula surgery. Women and girls need transport money, and often, if they have never travelled out of their villages, they may want to be accompanied by a relative. Some women may be deterred from going to hospitals far away from their homes. One health provider told us, “Women find far away hospitals alien. There is fear of not knowing where you are going; not knowing what to do.”²¹³ Two women told us that when they were told they could get treatment at KNH, they feared going there because it is in Nairobi and they do not know anyone there.²¹⁴ A nurse confirmed that women fear traveling far for treatment: “Women ask, ‘how do I get there? Who will I stay with? Who [will] I talk to?’”²¹⁵

²¹⁰ Human Rights Watch Interview with Dr. Khisa Wakasiaka, fistula surgeon and Fistula Program Officer, AMREF, Nairobi, November 11, 2009; Human Rights Watch interview with Dr. Stephen Mutiso, gynecologist and fistula surgeon, Machakos General Hospital, Nairobi, November 26, 2009; Human Rights Watch interview with Patrick Okumu, anesthetist, Webuye District Hospital, Kisii, November 9, 2009; Human Rights Watch interview with Dr. Geoffrey Okumu, fistula program coordinator, UNFPA, Nairobi, November 19, 2009; Human Rights Watch Interview with Amy Irving, Freedom From Fistula, Nairobi, December 3, 2009; Human Rights Watch interview with George Audi, hospital administrator, Jamaa Mission Hospital, Nairobi, December 2, 2009; and Dr. Issak Bashir, speaking at the Obstetric Fistula Stakeholders’ Meeting, School of Monetary Studies, Nairobi, February 4, 2009, attended by Human Rights Watch Researcher.

²¹¹ WHO, “Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development,” p. 24.

²¹² Human Rights Watch Interview with Dr. Khisa Wakasiaka, fistula surgeon and fistula program officer, AMREF, Nairobi, November 11, 2009.

²¹³ Human Rights Watch interview with Patrick Okumu, anesthetist, Webuye District Hospital, Kisii, November 12, 2009.

²¹⁴ Human Rights Watch interview Nyasuguta J., Kisii, 11, 1009; Human Rights Watch interview with Nyaboke H., Kisii, November 10, 2009.

²¹⁵ Human Rights Watch interview with Lilian Ndege, nursing officer in charge of the gynecology ward, Kisii General Hospital, Kisii, November 11, 2009.

Health System Financing, Funding for Maternal Health Care and Fistula Repairs

Kenya is obliged under international law to take steps, to the maximum of its available resources, to progressively realize the right to health. This requires making appropriate allocations from available budgets to health care, including reproductive and maternal health services. One measure of the adequacy of health care is its accessibility, including in terms of cost. International law also requires that the government provide free services where necessary to ensure women's right to safe motherhood.²¹⁶

The fact that poor women and girls and those residing in rural areas continually fail to access maternity and reproductive health services due to cost constraints implies the government has not been successful in ensuring equitable access to health.

The government has put in place policies such as waivers and exemptions for poor women and girls who cannot afford health charges, but these are ineffective in removing barriers to financial accessibility in cases where women continue to be charged informal user fees, are not aware of the waivers or exemptions, or are sometimes denied them. Lack of adequate oversight mechanisms to monitor and evaluate implementation of these and other policies undermine the progressive realization of the right to health.

A variety of mechanisms are used to fund public health services in Kenya, in line with the 1994 health policy framework: taxation, through the government of Kenya budget; development partner funding; and cost-sharing with users, both through insurance and through user fees.²¹⁷ The government has recently initiated policy changes aimed at improving health care financing. Efforts include expanding the output based approach (discussed in more detail below), to expand benefits under the National Hospital Insurance Fund (NHIF) to cover outpatient health services and to include people in the informal labor sector.²¹⁸ The focus of NHIF has been mainly on formal sector employees. This has left out many Kenyans working in sectors such as the informal sector, agriculture, and pastoralists. The government plans to transform the current NHIF to a National Social Health Insurance

²¹⁶ CEDAW, art. 12(2).

²¹⁷ Ministry of Health, "Kenya Public Expenditure Tracking Survey," 2007, p. 9.

²¹⁸ The National Hospital Insurance Fund was established in 1966. It currently covers around 25 percent of the population. The scheme is mandatory for those in the formal sector and voluntary for those in the informal sector. *Ibid.*, p. 11.

Fund (NSHIF) as a way of ensuring equity and access to health services by all Kenyans, especially the poor and those in the informal sector.²¹⁹

The budget is the government's single most important policy instrument as it shows the true priorities of the government. The budget can reveal whether the government is serious about its commitment to improving maternal and reproductive health care by allocating the necessary resources. Further, the budget can show whether funds are targeting the real challenges of and gaps in reducing maternal mortality and morbidity.²²⁰ Human Rights Watch is not in a position to do a detailed analysis of the budget. However, generally, funding for the health sector is considered inadequate by many, including donors, health providers, and government officials.²²¹ The Kenya government's own policies and documents indicate insufficient budgetary allocation as a key and longstanding challenge to improving health service delivery.²²² There is no Kenya government budget allocated to fistula. Funding for fistula repair services is all from foreign donors, although UNFPA channels its resources through the government. Government support for fistula repairs includes provision of hospital space and staff such as nurses and anesthetists.

There is no direct budget line for maternal and reproductive health, save for family planning. The health budget does not provide details of what aspects of maternal and reproductive health are funded by the government. In addition, in Kenya, drugs for all medical conditions, including maternity-related ones, are centrally bought, and this type of expenditure is not reflected in the health budget.²²³ The above make it difficult to determine what percentage of

²¹⁹ For more discussion on the NSHIF, see Diana N. Kimani et al., *Healthcare Financing Through Health Insurance in Kenya: The Shift To A National Social Health Insurance Fund*, KIPPRA Discussion Paper No. 42 (Nairobi: Kenya Institute for Public Policy Research and Analysis, 2004).

²²⁰ See International Budget Partnership, "Civil Society Budget Analysis and Advocacy as a Tool for Maternal Health Accountability," September 7, 2009, http://www.eurongos.org/Files/HTML/EuroNGOs/AGM/IBP_presentation_EURONGOsConf_FINAL.pdf (accessed June 25, 2010).

²²¹ Human Rights Watch Interview with Dr. Khisa Wakasiaka, fistula surgeon and fistula program officer, AMREF, Nairobi, November 11, 2009, Dr. Issak Bashir, speaking at the Obstetric Fistula Stakeholders' Meeting, School of Monetary Studies, Nairobi, February 4, 2009, attended by Human Rights Watch Researcher, and Human Rights Watch interview with Dr. Stephen Mutiso, gynecologist and fistula surgeon, Machakos General Hospital, Nairobi, November 26, 2009. Also see, GTZ Health Sector Programme Kenya, "Estimated Government Spending 2009/2010;" Ministry of Public Health and Sanitation and the Ministry of Medical Services, "Health Care Financing Policy and Strategy: Systems Change for Universal Coverage," November 2009, p.8; and Jeff Otieno and Dave Opiyo, "Kenya Lags Behind in Meeting Vision 2030 Targets," *The East African*, May 26, 2010.

²²² See GTZ Health Sector Programme Kenya, "Estimated Government Spending 2009/2010," p. 2. This figure excludes funding from development partners. Also see Ministry of Medical Services, "Ministry of Medical Services Strategic Plan, 2008 – 2012," p. 20; Ministry of Public Health and Sanitation and the Ministry of Medical Services, "Health Care Financing Policy and Strategy: Systems Change for Universal Coverage," November 2009, p.8.

²²³ Human Rights Watch interview with Martin Mosina, Senior Finance Officer, Ministry of Medical Services, Nairobi, June 24, 2010.

the health budget is being allocated to maternal health care and what areas are prioritized, and whether these are in line with interventions needed to reduce maternal mortality and morbidity. The Kenya government should develop a clear budget line for maternal health, with a particular focus on the poor and those living in rural areas. In addition, it should establish a system to track annual budget allocations for maternal health care, including information on what proportion of the health budget and total government budget is allocated to reproductive and maternal health care.

Lack of Reintegration Assistance

The World Health Organization recommends that countries addressing obstetric fistula attend to the reintegration and rehabilitation needs of women and girls who have undergone repair.²²⁴ Women need continued emotional and psychological support to ensure they regain self-esteem and happiness, to ensure reduced stigma and participation in social and religious life, to regain fertility and sexual life as desired, and to ensure future safe deliveries after fistula repair. While there have been achievements in making treatment available, the above needs are not being addressed. Currently there are no initiatives by the government or other service providers to facilitate social reintegration into the community.²²⁵ One doctor commented, “Now the interest is in surgery, tell me, who is doing rehabilitation? So the cause of the fistula may be social and economic. You do the surgery meticulously and you release the women into same environment which gave her the fistula and the factors are still in operation. We have seen women repaired. They go and heal and come back with another fistula.”²²⁶

Support for reintegration is particularly vital for women experiencing high levels of stigma, those with unsuccessful repairs, or those who are not continent after repair. Women and girls can experience stress incontinence after repair; this can be very traumatic and women may think the surgery was unsuccessful. The consequences may be the same as with actual fistula.²²⁷ Furthermore, women with such conditions may continue to experience stigma, discrimination, and even violence.

²²⁴ WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, p. 69.

²²⁵ The hospital administrator at Jamaa Hospital told us they were considering financial rehabilitation of fistula survivors by starting a revolving fund for women and girls who are treated. Human Rights Watch interview with George Audi, hospital administrator, Jamaa Mission Hospital, Nairobi, December 2, 2009.

²²⁶ Dr Julius Kiiru speaking at the Obstetric Fistula Stakeholders’ Meeting, School of Monetary Studies, Nairobi, February 4, 2009, attended by Human Rights Watch Researcher.

²²⁷ There is a lack of sufficient research on how well women reintegrate after fistula surgery, as well as models for reintegration and rehabilitation. In the experience of providers and advocates in Ethiopia, Nigeria, and Tanzania, totally cured

Costs to Users in the Public Health System

Poverty is one of the main reasons some women and girls cannot access quality maternal care services. Kenya is ranked 147 out of 182 countries on the United Nations Development Programme's Human Development Index.²²⁸ Per capita income is roughly US\$770 per year, which is about \$2 per day.²²⁹ Forty-six percent of Kenyans are living below the food poverty line.²³⁰ The country has been hard-hit by rising fuel prices, in turn affecting transport costs and food prices. According to the Health Financing Policy and Strategy, out-of-pocket health expenditure is high in Kenya, particularly among rural and poor populations, and accounts for a large share of total health expenditure.²³¹

User Fees

User fees, as part of cost-sharing in the health sector in Kenya, have been operational since 1992. In an effort to lessen the negative impact of user fees, Kenya introduced a user fees reduction policy in 2004 commonly referred to as the 10/20 policy, which made health services from the lowest-level facilities (dispensaries and health clinics) very affordable. Under the policy, services at dispensaries and health centers are to be free for all citizens, except for a minimum registration fee of KSH 10 at dispensaries and KSH 20 at health centers (approximately \$0.13 and 0.27 respectively).²³²

Removing user fees for maternity services can greatly improve access to care.²³³ Kenya has taken the important step of making childbirth free in dispensaries and health centers, but

women can and do reintegrate back into their community and are able to carry on with life, including remarrying and having further pregnancies. However, WHO cautions that, "While it appears that successful repair may well lead to a smooth transition/reintegration when returning home; further research is needed to identify specific challenges to the quality of life of these women and the degree to which they are reintegrated." WHO, *Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development*, p. 12.

²²⁸ United Nations Development Programme, "Human Development Report 2009, Kenya," http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_KEN.html (accessed March 29, 2010).

²²⁹ DFID, "About Kenya," <http://www.dfid.gov.uk/Where-we-work/Africa-Eastern--Southern/Kenya1/Key-facts1/> (accessed March 29, 2010).

²³⁰ Ibid.

²³¹ See Ministry of Public Health and Sanitation and the Ministry of Medical Services, "Health Care Financing Policy and Strategy," pp. 9-11. Human Rights Watch has previously written about inability of poor families to access health care due to financial constraints. See Human Rights Watch, *A Question of Life and Death: Treatment Access for Children Living with HIV in Kenya* (New York: Human Rights Watch, 2008), p. 45.

²³² As of April 2010, one US dollar was worth KES 75.

²³³ WHO for example has argued that, "One of the keys to improving women's health therefore, is the removal of financial barriers to health care.... Evidence from several countries shows that removing user fees for maternal health care, especially for deliveries, can both stimulate demand and lead to increased uptake of essential services. Removing financial barriers to care must be accompanied by efforts to ensure that health services are appropriate, acceptable, of high quality and

there is a charge for delivery in higher-level public hospitals. There, charges for normal delivery range from KSH 1,500 to KSH 3,000 (roughly \$20 and \$40) while Cesarean section births average KSH 6,000 to KSH 8,000 (approximately \$80 to \$106).

The cost of fistula surgery in public hospitals is about the same as for a Cesarean section operation. These fees exclude the cost of transportation to the hospital and post-operative care that is vitally important to prevent infection. User fees create a significant barrier to women's access to quality reproductive and maternal health services and put them at risk of death or injury when they are forced by poverty to deliver at home under unskilled care. Except for the few who hear announcements about free fistula repair camps, cost can deter women living with the condition from seeking treatment.

User Fee Exemptions

The government has implemented a user fee exemption policy.²³⁴ In addition to childbirth in dispensaries and health centers, other services exempted include treatment of children aged below five years, and care for specific health conditions such as malaria, antiretroviral treatment for HIV/AIDS, and tuberculosis.²³⁵

Fully exempt reproductive health services in all levels of government facilities include antenatal care, postnatal care, and family planning. A proposal for a broader maternal health care exemption, which would make delivery in all government facilities free, by the former Minister for Health, did not succeed.²³⁶ Although supposedly an exempt service, women do incur both formal and informal fees when accessing family planning services.²³⁷ The

responsive to the needs of girls and women." See WHO, *Women and Health: Today's Evidence Tomorrow's Agenda* (Geneva: WHO, 2009), http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf (accessed November 24, 2009), p. xiv.

²³⁴ Division of Health Care Financing, Ministry of Health, "Facility Improvement Fund, Supervision Manual," 2002, pp.18-21.

²³⁵ Jane Chuma et al., "Reducing User Fees for Primary Health Care in Kenya: Policy on Paper or Policy in Practice?," *International Journal for Equity in Health*, vol. 8 (2009), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2683851/> (accessed November 23, 2009).

²³⁶ Minister Charity Ngilu argued against cost-sharing and tried to introduce a social health insurance bill in parliament, but it did not get a presidential assent "as it failed to provide a credible roadmap on implementation, affordability for the poor and viability of the system." See Ministry of Public Health and Sanitation and the Ministry of Medical Services, "Health Care Financing Policy and Strategy," p.2. These efforts are still ongoing.

²³⁷ According to the 2008-09 Kenya Demographic and Health Survey, 72 percent of women who obtain contraceptives from the public sector paid some fees, although it does not define what fees were paid. KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. 68. The 2004 Kenya Service Provision Assessment Survey had found that, "Overall 23 percent of family planning facilities charge fees for maintaining the client record; 19 percent charge for the family planning consultation, and 24 percent charge for the contraceptive method itself." NCAPD et al., "Kenya Service Provision Assessment Survey 2004," p. 9.

government has not instituted monitoring mechanisms to ensure that health facilities do not charge for exempt services.²³⁸

User Fee Waivers

The government has implemented a general waiver system in public facilities for those who cannot meet their medical costs. The policy says: “A *waiver*... is a release from payment based on financial hardship at a particular point in time and it *is not* automatic. Patients must request a waiver and judgment must be made as to whether or not the patient is truly a hardship case.”²³⁹ The aim of the policy is to “ensure that no patient is denied essential health care because of inability to pay.”²⁴⁰ Priority is supposed to be given to vulnerable groups such as children under the age of five, street families, maternal and child health services, and referral cases.²⁴¹ There are no defined health providers authorized to grant waivers. The hospital administrator is charged with the duty of assigning responsibility to grant waivers.²⁴² Human Rights Watch interviews with two government officials, doctors, and nurses indicate that waivers are administered by a wide range of health providers, including medical social workers, health administration officers, and nursing officers.²⁴³

Human Rights Watch found that implementation of the waiver policy is poor for a number of reasons. The criteria for determining the financial need of a patient—such as mode of dress—are vague and easily manipulated by patients and hospital reviewers.²⁴⁴ Furthermore,

²³⁸ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009; Human Rights Watch interview with Dr. Samuel Were, head, Health Sector Reform Secretariat, Nairobi, December 22, 2009; Human Rights Watch interview with Dr. Geoffrey Otumu, medical superintendent, Kisii General Hospital, Kisii, November 8, 2009.

²³⁹ Division of Health Care Financing, Ministry of Health, “Facility Improvement Fund, Supervision Manual,” p. 19.

²⁴⁰ *Ibid.*, p. 20.

²⁴¹ *Ibid.*, p. 19.

²⁴² *Ibid.*, p. 21.

²⁴³ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009; Human Rights Watch interview with Dr. Samuel Were, head, Health Sector Reform Secretariat, Nairobi, December 22, 2009; Human Rights Watch interview with Dr. Geoffrey Otumu, medical superintendent, Kisii General Hospital, Kisii, November 8, 2009; Human Rights Watch interview with Jessica Momanyi, nursing officer in charge of reproductive health, Kisii General Hospital, Kisii, November 11, 2009; Human Rights Watch interview with Esther Mbinzi, nurse in the gynecology ward, Machakos General Hospital, Machakos, December 6, 2009; Human Rights Watch interview with Dr. Stephen Mutiso, gynecologist and fistula surgeon, Machakos General Hospital, Nairobi, November 26, 2009.; Human Rights Watch interview with Patrick Okumu, anesthetist, Webuye District Hospital, Kisii, November 9, 2009; Human Rights Watch interview with Dr. Gulid Yusuf, medical superintendent, Garissa Provincial General Hospital, Nairobi, November 26, 2009; Human Rights Watch interview with Dr. Paul Mitei, fistula surgeon, Kisumu Provincial General Hospital, Nairobi, November 26, 2009; Human Rights Watch interview with Christine Muthengi, fistula care trainer, Kenyatta National Hospital, Kisii, November 11, 2009.

²⁴⁴ The policy says that the “Decision for granting a waiver of not should be based on history taking and close observation of the socio-economic status of the patient and his/her relatives.” Division of Health Care Financing, Ministry of Health, “Facility

hospitals do not always publicize the availability of waivers despite a government requirement to do so.²⁴⁵ The three public hospitals visited by Human Rights Watch did not tell patients that they could apply for waivers. Hospitals fear misuse of the waiver service, hence the failure to publicize. Emily Wasungu, the nursing officer in charge of the labor ward at Kisumu Provincial General Hospital told us, “We don’t give them information because it can be misused.”²⁴⁶ Another health provider had a similar comment: “[There are] big fears on misuse of service.” He explained: “Patients want the waiver all the time and tell friends and relatives. Staff members misuse the waiver. Chiefs [community-level provincial administrators] write letters for people who are not in need and patients will go extra miles such as dressing in old clothes to appear poor.”²⁴⁷ A government official told us, “Members of staff in a good number of hospitals collude with or try to influence decisions on waiver.”²⁴⁸

For the waiver system to be effective in enhancing access to health care for the poor, the population should be informed about the existence of such a policy. Almost all the women we spoke to had never heard about the waiver policy. One woman had asked for a waiver in a hospital and was told it did not exist:

I asked at Machakos if they could do the repair for free because I did not have any money and I was told I needed KSH 6,000 (\$80). But I had no money.... I asked the nurse, “I hear you can help poor people.” She told me, “That [does] not happen here.” My only option was to sell land but I would rather stay with the problem than sell my land because it is my only source of food.²⁴⁹

Improvement Fund, Supervision Manual,” p. 21. Other information to be noted include occupation, number of children, means of transport, alcohol and cigarette consumption, and type of clothing. *Ibid.*, p. 21.

²⁴⁵ Division of Health Care Financing, Ministry of Health, “Facility Improvement Fund, Supervision Manual,” p. 21. The policy says that all health facility staff should be informed about the operation of the waiver system, and that all patients should be about the waiver system. *Ibid.*

²⁴⁶ Human Rights Watch interview with Emily Wasungu, nursing officer in charge of the labor ward, Kisumu Provincial General Hospital, Kisumu, December 9, 2009.

²⁴⁷ Human Rights Watch interview with Patrick Okumu, anesthetist, Webuye District Hospital, Kisii, November 9, 2009.

²⁴⁸ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009.

²⁴⁹ Human Rights Watch interview with Kanyua L., Machakos, December 7, 2009. A study conducted on user fees in five countries, including Kenya, stated that “Generally, women ... were not aware of the waiver/exemption mechanisms for maternal health services.” Sharma et al., “Formal and Informal Fees for Maternal Health Care Services in five Countries,” p. vii.

Although one of the doctors said he had obtained a waiver for a woman needing fistula surgery,²⁵⁰ our research found that the waiver system has not made a great difference in ensuring poor women and girls access maternal health services. Addressing cost as a barrier to fistula repair, Dr Josephine Kibaru, the head of the Department of Family Medicine in the Ministry of Public Health and Sanitation noted that majority of fistula survivors are poor and remarked, “There should be no discussion. These [fistula survivors] are waiver cases.”²⁵¹

Health care facilities usually absorb the costs of both administering the waiver system and providing the services they have waived, limiting its effectiveness:

The important role for user-fees as a mechanism for healthcare financing is curtailed largely due to lack of third party payment for the cost of waivers and exemptions instituted to protect and guarantee access by the needy. As a result, the fee levels have been kept low, thereby undermining its revenue generating potential, and consequently its ability to support increased provision and availability of quality services.²⁵²

Another problem in the implementation of waivers is that some health care users tend to have little knowledge about the existence and implementation of the waiver system. Although the waiver policy says that hospitals should assign people responsibility to grant waivers, our interviews with nurses, doctors and hospital administrators show that this is not always the case. While many of them knew about the existence of the waiver policy, some of them could not tell us the process of obtaining a waiver or who, in their respective health facilities makes the decision to grant the waiver. A government official acknowledged that these information gaps exist and commented, “It is true that some staff are not aware [about the application of the waiver policy]. Those that were trained have left. We realize the need for catch-up training.”²⁵³

²⁵⁰ Human Rights Watch interview with Dr. Gulid Yusuf, medical superintendent, Garissa Provincial General Hospital, Nairobi, November 26, 2009.

²⁵¹ Dr. Josephine Kibaru speaking at the Obstetric Fistula Stakeholders’ Meeting, School of Monetary Studies, Nairobi, February 4, 2009, attended by Human Rights Watch Researcher.

²⁵² Ministry of Public Health and Sanitation and the Ministry of Medical Services, “Health Care Financing Policy and Strategy,” p.11.

²⁵³ See Sharma et al., “Formal and Informal Fees for Maternal Health Care Services in Five Countries,” p. 2, discussing providers’ lack of awareness about which services are exempted or how the waiver system works.

The Kenya government should publicize the existence of the waiver system and procedures for obtaining one. All health facilities should be required to publicly display such information. The government should also develop and implement mechanisms to monitor health facilities' compliance with the waiver policy.

VI. Patients' Rights and Health System Accountability

Health system accountability has received little attention in Kenya. Accountability in the context of the right to the highest attainable standard of health “is the process which provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. Equally, it provides government with the opportunity to explain what they have done and why.”²⁵⁴ Accountability is central to women’s right to health and to reducing preventable maternal mortality and morbidity. It begins with the government ensuring the incorporation and implementation of accessible, easily understood, and effective accountability processes into the health system.

Several processes enhance health system accountability. Grievance redress is key. When women are mistreated in health facilities or when they are unhappy about the quality of services offered, it is important that they have access to effective mechanisms to address concerns or complaints. Such mechanisms would not only enhance their trust in the health system but also improve utilization and effectiveness of maternal health services. Another component of health system accountability involves ensuring non-recurrence of systemic failures and gaps. Persistent problems with access to emergency obstetric care, mistreatment by health providers or poor referral systems indicate accountability deficits.

Mistreatment and Neglect by Health Care Providers

Abuse of women in health facilities when they go to deliver is a longstanding problem in the Kenya health sector. Although Human Rights Watch interviewed few women who had been abused during delivery, a study looking exclusively at abuse of women during childbirth by the Federation of Kenya Women Lawyers (FIDA Kenya) and the Center for Reproductive Rights documented decades of rights violations including verbal and physical abuse.²⁵⁵

²⁵⁴ Helen Potts, “Accountability and the Right to the Highest Attainable Standard of Health,” 2008, http://www.essex.ac.uk/human_rights_centre/research/rth/docs/HRC_Accountability_Maro8.pdf (accessed October 30, 2009), p.3.

²⁵⁵ See FIDA Kenya and Center for Reproductive Rights, “Failure to Deliver: Violations of Women’s Human Rights in Kenyan Health Facilities,” 2007, (accessed November 4, 2009). Human Rights Watch spoke to six women, who had given birth within a range of 20 years to 3 months from the time of the interview, who said they had been verbally and physically abused by health providers while in labor. One of them Awino A. who had labored at home for more than 15 hours before going to the nearest district hospital told us, “We arrived at the hospital around midday. Two nurses took me to the labor ward and they kept telling me to push. After sometime they left me alone. Occasionally, a nurse would come by and hit me telling me I got pregnant because I enjoyed sex and if I don’t push I will kill my baby. They would slap and pinch my thighs.” Seventeen-year-old Monica E. told us, “I was in so much pain when we arrived at the hospital. The nurse who took me to the labor ward told me, ‘stop behaving as if you are in pain because this is what you were looking for. Why was a young girl like you having

Abuse of women during labor often coincides with negligence in providing care. We spoke to women and girls who told us that they were left unobserved for many hours at health facilities. When 17-year-old Akello Z. started labor in 2007, her grandmother immediately called a TBA. Two days later, she had not delivered and her grandmother borrowed money to take her to the nearest dispensary, but she found no help there: “We got to the dispensary at about midday. I was examined by a nurse and she said I had to wait. I was near to deliver. I stayed at the dispensary until the following day at around 7 a.m. The nurse just left me alone and told me ‘next time you will think when you are enjoying sex.’ In the morning she did not check me. She just said they could not help me and I should go to another hospital.”²⁵⁶ Awino A. (abuse case described above) told us, “They kept telling me to push. After some time they left me alone. At night no one came to see me at all. At around 5 a.m., a doctor came to the ward and was shocked and asked the nurses why they had kept me for so long without referring me and the baby was dead.”²⁵⁷ Another woman narrated her ordeal to us,

I started labor at about midnight. I told my sister-in-law and she immediately took me to the general hospital which is about half an hour walk from where we were staying. At the hospital they examined me and said I was not due but I was in so much pain and the water had already broken. The nurse took me to the labor ward and told me to push but the baby was not coming out. I was in pain for three days. On the third day they called a doctor who came and pulled out the baby using a metal [forceps] because the baby was already dead.²⁵⁸

A senior government official told us: “We have started this process of visiting hospitals. We were in Webuye in October [2009] and went to the labor ward and found one pregnant woman in the labor ward who had stayed for two days and had not been reviewed.”²⁵⁹

In 2002, in collaboration with various professional bodies, the Ministry of Health developed Standards for Maternal Care in Kenya that aim to provide women with “good quality care ... [ensure] dignity during childbirth ... prevent the aspects of care that are disrespectful and

sex?” Two other girls said that when they expressed pain, nurses had told them not to pretend to be in pain because they had enjoyed the sex. Human Rights Watch interviews with Awino A., Nairobi, November 26, 2009; Monica E., Nairobi, December 2, 2009; Eunice F., Kisumu, December 9, 2009; and Monica J., Nairobi, December 2, 2009.

²⁵⁶ Human Rights Watch interview with Akello Z., Kisii, November 11, 2009.

²⁵⁷ Human Rights Watch interview with Awino A., Nairobi, November 26, 2009.

²⁵⁸ Human Rights Watch interview with Apondo C., Nairobi, December 2, 2009.

²⁵⁹ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009.

unnecessary which will impact negatively on the confidence of women in using a specific facility.”²⁶⁰ The standards state as an outcome criteria that women “are not addressed rudely.”²⁶¹ The Standards for Maternal Care also stipulate that, “Every woman in labour in a health facility [be] monitored with a partograph [or] ... [be] delivered or referred within 1 hour of diagnosis [with obstructed labor].”²⁶² Generally, use of partographs—charts for monitoring progress of labor—is low. An assessment survey of health facilities in 2004 found that “39 percent of facilities offering delivery services have blank partographs.”²⁶³

Substandard care happens at all levels of facilities. A study by UNFPA and the Population Council that included a review of hospital records of women in obstructed labor who underwent Cesarean sections concluded that the “quality of care in referral facilities requires improvement.”²⁶⁴ For example they found that, “Blood for grouping and cross matching was taken in 76 percent of the cases but worryingly in only 37 percent of the cases were IV fluids commenced once diagnosis of obstructed labour was made. Only half of the case notes reviewed was a urinary catheter inserted prior to C/S.”²⁶⁵ More than half of health care providers interviewed by Human Rights Watch confirmed the occurrence of these failings. Some, especially nurses, linked them to poor working conditions. One nurse commented, “Provider attitude is a problem especially with young girls.... You meet one nurse taking care of 70 patients. In the morning you are just crazy.”²⁶⁶ A doctor told us, “In North Eastern, you find one nurse attending to women, children, and men. How can she offer good care?”²⁶⁷ Another one said, “It is true that some nurses neglect patients, but in some cases it is

²⁶⁰ National Joint Steering Committee for Maternal Health Kenya, “Standards for Maternal Care in Kenya,” p.7.

²⁶¹ *Ibid.*

²⁶² National Joint Steering Committee for Maternal Health Kenya, “Standards for Maternal Care in Kenya,” 2002, p.3. The Standards were developed by the National Nurses Association of Kenya and the Kenya Obstetricians and Gynaecologists Society and are focused on provision of emergency obstetric care in hospitals and health centers. A partograph is a graphical record of progress during labor. Progress is measured by cervical dilation against time in hours. As well the partograph provides a record of the important conditions of the mother and fetus that may arise during the process of labor. The partograph is a useful tool for managing obstructed labor. Skilled practitioners can use it to recognize and deal with slow progress before labor becomes obstructed and if necessary, ensure that Caesarean section is performed on time to save the mother and the fetus. WHO, “Maternal Mortality: Fact Sheet,” 2008, http://www.who.int/making_pregnancy_safer/events/2008/mdg5/factsheet_maternal_mortality.pdf (accessed May 12, 2010), p. 2.

²⁶³ NCAPD et al., “Kenya Service Provision Assessment Survey 2004,” p.xxv.

²⁶⁴ UNFPA and Population Council, “Obstetric Fistula: Can Community Midwives Make a Difference?,” p. iv.

²⁶⁵ *Ibid.*

²⁶⁶ Human Rights Watch interview with Lilian Ndege, nursing officer in charge of the gynecology ward, Kisii General Hospital, Kisii, November 11, 2009.

²⁶⁷ Human Rights Watch interview with Dr. Elly Odongo, gynecologist and fistula surgeon at Garissa Provincial Hospital, Nairobi, November 26, 2009.

capacity issues. Our dispensaries and health centers and even hospitals are so poorly staffed. You wonder when this problem will end.”²⁶⁸

Bad treatment of women and girls in health facilities can have indelible psychological effect and deter women from using health facilities in general. In the case of fistula, it can deter them from going for follow-up care or seeking further medical treatment in case of unsuccessful surgery. Muthoni M. had a negative experience when she took her child to Embu Provincial hospital in 2007. When she got fistula in 2009, she did not go to hospital for fear she would not be helped: “They just toss you from one person to another. I was referred there to take the baby because she had diarrhea and a cough. The child was very ill. Instead they kept me waiting. I had to go back home. They talk very badly. They don’t even care. I could not go back there.”²⁶⁹ A nurse at Railways Dispensary in Kisumu observed, “If a mother goes to a facility and she is not helped, it stops other women from going.”²⁷⁰

Inadequate Patients’ Rights and Grievance Mechanisms

Despite documented evidence of abuse and neglect in the health sector in Kenya, no effective formal mechanisms have been developed to respond to grievances and provide redress when patients’ rights are violated. Accountability includes the monitoring of conduct, performance, and outcomes. In this regard, and in order to correct systemic failures in reducing maternal morbidity and mortality and thereby assist the government to progressively realize the right to health, it is important to get feedback from patients on the quality and acceptability of services provided. There should be accessible and effective ways of providing such feedback, lodging complaints, and ensuring such feedback is acted upon. This requires the government to inform patients about their rights and entitlements and how to access redress mechanisms. By not adequately providing information about entitlements under existing healthcare policies and by failing to implement effective grievance redress procedures, the government is falling short of its obligation to guarantee the right to a remedy.

Service Charter for Health Service Delivery

The two ministries of health have a “Service Charter for Health Service Delivery.” It states,

²⁶⁸ Human Rights Watch Interview with Dr. Stephen Mutiso, gynecologist and fistula surgeon, Machakos General Hospital, Nairobi, November 26, 2009.

²⁶⁹ Human Rights Watch interview with Muthoni M., Machakos, December 6, 2009.

²⁷⁰ Human Rights Watch interview with Isabela Sure, nurse, Rabuor dispensary, Kisumu, December 9, 2009.

The Government is committed to provision of efficient and high quality health care that is accessible, equitable and affordable to every Kenyan.... The purpose of this charter is to provide the public with our core functions and values, information on the range of services we offer, our commitments, principles, obligations, customers' rights and obligations, mechanisms for complaint and redress for any dissatisfied clients and customers.²⁷¹

However, the charter does not explain when, how, and to whom patients can complain, nor does it talk about redress.

Citizens' Service Charters

The two health ministries have also developed Citizens' Service Charters. The Ministry of Public Health and Sanitation's (MoPHS) "Citizens Service Delivery Charter" promises "to provide quality preventive and promotive health services to all our clients with dignity, professionalism and within the shortest time possible."²⁷² It gives a list of services rendered, the patient responsibilities, user charges, and the expected waiting time. In addition, it spells out health services that are exempt from payment including deliveries in dispensaries and health centers, but it does not mention family planning services.

The Ministry of Medical Services has developed a "Citizens Service Charter for Delivery of Medical Services for District Hospitals," which is more elaborate than the MoPHS one. It advises patients that they can complain about unsatisfactory services and where they can do so: "Any service that does not conform to the above standards or an officer who does not live up to the commitment to courtesy and excellence in service delivery should be reported to the Out-Patient Department Nursing Officer in-charge or any Hospital administrator."²⁷³ It says that childbirth is only free in health centers and dispensaries. However, it does not indicate that family planning, antenatal care, and postnatal care are also free.

²⁷¹ Ministry of Health, "Service Charter for Health Service Delivery," 2006, www.medical.go.ke (accessed January 20, 2010), p. 5. The Rights mentioned in the charter include, right to care by qualified health provider, right to accurate information, right to timely service, right of choice of health provider/service, right to protection from harm or injury, right to privacy and confidentiality, right to courteous treatment, right to dignified treatment, right to continuity of care, right to personal/own opinion, right to emergency treatment anywhere, and right to dignified death.

²⁷² Ministry of Public Health and Sanitation, "Citizens Service Delivery Charter," www.publichealth.go.ke, (accessed January 20, 2010).

²⁷³ Ministry of Medical Services, "Citizens Service Charter for Delivery of Medical Services for District Hospitals," undated.

Patients' Rights Charter

In 2006, the Ministry of Health developed a patients' rights charter²⁷⁴ that hospitals are supposed to display strategically, but, based on facility visits by Human Rights Watch, this is not always done. Also, there seems to be no effort to enable illiterate patients to understand their rights and to lodge grievances. There are no public awareness campaigns on patients' rights and grievance mechanisms. A government official confirmed that patients are not educated about their rights:

Something that the ministry started but has not expanded is the patients' rights. Public health education also died along the way. There is this poster [he shows a poster that talks about patients rights and that he says should be displayed in hospitals] in my office but hospitals are not showing them. I have been to several hospitals and they don't show them.²⁷⁵

A nurse at Machakos General Hospital told us, "Patients can inform the nursing officer at the administration block if they have grievances against nurses," but added, "We don't tell patients that they can complain. Some read the patients' rights we have displayed on the wall."²⁷⁶ She also informed us that she knew of no clear system for dealing with providers who are reported by patients. Instead, there are ad hoc measures such as being called before a disciplinary committee and warned.

Suggestion Boxes

Even patients who are aware of their rights and feel aggrieved at how they are treated in health facilities have limited ways of registering and processing complaints. The current system of using suggestion boxes is ineffective. All the hospitals we visited had a suggestion box. When we asked various hospital staff how they used this system to address grievances, for example the types of complaints received, processes to deal with them, and their outcomes, most did not know how this system worked. According to a government respondent, "There is a structure but it is not being followed.... Hospitals should have complaint boxes, at least four, strategically displayed in hospitals. These need to be

²⁷⁴ Ministry of Health, "Patients Rights Charter," 2006.

²⁷⁵ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009.

²⁷⁶ Human Rights Watch interview with Esther Mbinzi, nurse in the gynecology ward, Machakos General Hospital, Machakos, December 6, 2009. The patient's rights charter seen by Human Rights Watch was an A4 size document in English. It is highly unlikely patients will see it, and many may not speak English or be literate.

reviewed by advisory committees but this is not being done.”²⁷⁷ The Director of Public Health in the Ministry of Public Health and Sanitation concurred: “[The] complaint mechanism is not effective. Patients don’t complain.”²⁷⁸

Some women and girls interviewed by Human Rights Watch reported that they were too afraid to complain against doctors or nurses even when they felt that they had experienced some injustice for fear of reprisals. One told us, “Some nurses were not good to me at the hospital. They refused to change my beddings telling me why don’t you use the things that people use at home to stop the urine from coming out. I did not complain because I feared they will not treat me.”²⁷⁹

Accountability and the Community Strategy

One of the objectives of the Community Strategy is “Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility based health services”²⁸⁰ by ensuring that health providers adhere to the Citizen’s Service Charters.²⁸¹ The Community Strategy is a good avenue to educate communities about their rights and to link communities with health facilities to strengthen existing systems. As one health NGO worker noted, “Strengthening accountability “[C]an be very helpful.... Not everything can be solved by [reducing] the costs [of maternity care].”²⁸² Or, as another health professional observed, “It [accountability] will address the impunity culture of ‘even if I don’t help you, what will you do?’”²⁸³

²⁷⁷ Human Rights Watch interview with Sam Munga, head, Health Care Financing Division, Nairobi, December 16, 2009.

²⁷⁸ Human Rights Watch interview with Dr. Shanaz Shariff, Director of Public Health, Nairobi, December 4, 2009.

²⁷⁹ Human Rights Watch interview with Kasyoki E., Machakos, December 6, 2009.

²⁸⁰ Ministry of Health, “Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services,” 2006, p. 3.

²⁸¹ *Ibid.*, p. 8.

²⁸² Human Rights Watch interview with Sam Mulyanga, Programme Officer, Family Care International, Nairobi, December 11, 2009.

²⁸³ Human Rights Watch interview with Angela Nguku, coordinator, White Ribbon Alliance Kenya, Nairobi, 11, 2009.

VII. Detailed Recommendations

To the Ministry of Public Health and Sanitation and the Ministry of Medical Services

On a National Fistula Strategy

- Develop and implement a national fistula strategy in accordance with the World Health Organization’s “Obstetric Fistula: Guiding Principles for Clinical Management and Programme Development.” Other relevant government ministries, such as the Ministry of Gender and Children Affairs, and NGOs should participate in the conception of the strategy.

On Fistula Awareness and Education

- Carry out an awareness-raising campaign to inform the public about the causes of fistula, contributing factors and risks (such as female genital mutilation, early marriage and childbearing, and lack of skilled care at delivery), and the availability of treatment. Involve provincial administrators, religious leaders, and NGOs in the campaign.
- Incorporate information about fistula and availability of treatment services into the “Malezi Bora” (child-mother health and nutrition campaign) weeks.
- Integrate information on fistula into the Community Strategy by:
 - Strengthening messages in the Community Strategy on pregnancy and childbirth by developing specific messages on obstetric complications, including obstetric fistula, and translate these into Kiswahili and local languages.
 - Training community health extension workers and community health workers to educate communities about fistula, and to identify and refer for treatment women and girls with fistula.
- Integrate fistula information, including on facilities where treatment is available, into in-service training of health providers, and into antenatal and postnatal care services.
- Encourage nongovernmental organizations who work with communities on reproductive and maternal health issues to incorporate fistula awareness into their programs.

On School-Based Sexuality Education

- Make comprehensive sexuality education part of the school syllabus so that teachers can allocate time to teach it.

On Economic Access Barriers to Maternity Services and Fistula Treatment

- Urgently improve financial accessibility of fistula surgery by subsidizing routine repairs in provincial and district hospitals, including follow-up visits, and providing free fistula surgeries for indigent patients.
- Assess the feasibility of exempting fees for maternal health care in all health facilities beyond the current exemption for childbirth in dispensaries and health centers.
- Prioritize the completion and implementation of the National Social Health Insurance Fund to improve women's access to maternal health care.
- Publicize the cost of maternal health services:
 - Include in the Citizen's Service Charters the cost of all maternity services and indicate which services are exempt from payment, and translate it into Kiswahili and local languages.
 - Require that all health facilities display the Citizen's Service Charters in strategic locations and monitor compliance.
 - Publicize the existence of the waiver system and procedures for obtaining a waiver, including through translating these into Kiswahili and other local languages, and requiring facilities to display them.
 - Monitor facilities to ensure that user fees are charged as outlined and exemptions and waivers are applied. Collect gender-disaggregated data on this.

On Budgeting for Maternal Health Care

- Establish a system to track annual budget allocations for maternal health care, including information on what proportion of the health budget and total government budget is allocated to reproductive and maternal health care.

On Access to Emergency Obstetric Care and Health System Strengthening

- Urgently strengthen emergency obstetric care by:
 - Scaling up the number of health facilities that offer emergency obstetric care and intensifying efforts to meet the recommended ratios for staffing in health facilities.
 - Developing and implementing guidelines on the management of obstructed labor and oversight of this health service in line with the WHO's handbook on monitoring emergency obstetric care.

- Conducting refresher training for health providers and monitoring the use of partographs in health facilities, and widely disseminating and monitoring implementation of the Standards for Maternal Care.
- Implementing the referral component of the Community Strategy, including strengthening education on male involvement in birth planning and emergency preparedness.
- Improving communication between communities and community health facilities, through provision of toll free emergency numbers.
- Improving emergency transport between facilities by providing more ambulances, especially to service dispensaries and health centers.
- Prioritizing the completion and implementation of the referral strategy.

On Facilities and Training of Fistula Surgeons

- Work with the University of Nairobi and other institutions that train doctors and nurses to ensure that obstetricians and gynecologists get adequate skills on fistula identification during training, and support the training of adequate numbers of surgeons.
- Provide necessary equipment and supplies to hospitals that have trained fistula surgeons to facilitate routine repair.
- Work with donor partners to support long-term mentoring of surgeons undergoing fistula training.

On Fistula Data Collection and Monitoring

- Develop a tool for routine obstetric fistula data collection in health facilities and in communities through community health workers and community health extension workers.
- Integrate inquiries on fistula into future demographic health surveys and service provision assessment surveys.
- Consider integrating fistula review, through community-based interviews, into the community strategy.

On Patients Rights and Complaint Mechanisms

- Conduct public awareness programs to educate patients about their rights.
- Translate into local languages and widely disseminate the Service Charter for Health Service Delivery, the Citizens' Service Charters, and the Patients' Rights Charter.

- Require that all health facilities display these documents visibly and encourage patients to read them.
- Require all health facilities to develop formal internal complaint mechanisms with clear procedures that are widely publicized, and monitor their implementation.
- Conduct mandatory training for all health providers on patients' rights.
- Strengthen messages on patients' rights in the Community Strategy and include the right to redress.

To the Ministry of Justice, National Cohesion and Constitutional Affairs; Ministry of Foreign Affairs; and Attorney General

- Ratify the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).

To the Ministry for Gender and Children Affairs

- Together with the Ministry of Public Health and Sanitation, develop a strategy to systematic, comprehensive sexuality education for in- and out-of-school adolescents.
- Raise public awareness about the dangers of early marriage and female genital mutilation, including obstetric fistula, and monitor adherence to laws on early marriage and FGM.
- Improve cooperation between health and child protection from the community level to the national level as part of the current review of the child protection system.
- Ensure that the current child protection strategy includes measures to protect girls from stigmatization and abuse due to early pregnancy or fistula.

To the Kenyan National Assembly

- Enact the National Social Health Insurance Bill, ensuring that the planned National Health Insurance Fund provides health care for all women and girls.

To the African Union Commissioner for Social Affairs

- Encourage the Kenya governments to monitor annual budget allocations for maternal health care.
- Encourage the Kenya government to ratify the Maputo Protocol.

To the United Nations Population Fund

- Expand prevention activities of the Campaign to End Fistula and intensify work on rehabilitation and reintegration of fistula survivors.
- Offer the Kenya government technical and financial support to conduct further research on the prevalence and incidence of fistula.
- Expand efforts to train selected women who have had successful surgery to be community educators and support them to do so.
- Work with the African Union to integrate fistula into the Campaign for Accelerated Reduction of Maternal Mortality in Africa.

To the United Nations Children's Fund

- Support NGOs and civil society organizations to raise public awareness about the dangers of early marriage and female genital mutilation, including obstetric fistula.
- Encourage and support provision of systematic, comprehensive sexuality education for in- and out-of-school adolescents.
- Consider supporting, as part of protection work, rehabilitation and reintegration into communities of girls who have undergone fistula repair.

To Donor Countries and International Agencies

- Continue to offer the Kenyan government technical and financial support to address health system gaps that lead to poor quality maternal health care.
- Support efforts to improve access to health care through improved health financing systems. In particular, support steps to make reproductive and maternal health care services more affordable.
- Continue to offer the Kenyan government technical and financial support to improve emergency obstetric care, and prioritize improved access by poor, illiterate, and rural women.
- Provide technical and financial assistance to ensure that all government health interventions, particularly interventions funded by them, are monitored and evaluated to ensure that they are reaching poor, illiterate, and rural women.

VIII. Appendix I

Relevant Health Sector Policies, Strategies, and Guidelines

National Reproductive Health Policy (NRHP)

In 2007, Kenya’s first-ever NRHP was developed to complement the NRHS (see below) by providing a framework for equitable, efficient, and effective delivery of high-quality reproductive health services throughout the country with an emphasis on reaching those in greatest need and most vulnerable.²⁸⁴ It has four main areas of focus: safe motherhood, maternal and neonatal health, family planning, and adolescent/youth sexual and reproductive health and gender issues.

The NRHP states that traditional birth attendants “are not recognized as providers of skilled care,” and they should be used as advocates of safe childbirth through encouraging and referring to health facilities women who seek their services.²⁸⁵

The National Reproductive Health Strategy (NRHS) 2009-2015

The Government launched the National Reproductive Health Strategy (NRHS) 2009-2015 to “[F]acilitate operationalization of the National Reproductive Health Policy.”²⁸⁶ In addition, the strategy aims to improve financing for reproductive and maternal health care and to facilitate implementation of the reproductive and maternal health aspects of the Community Strategy.²⁸⁷ Some of its objectives are to markedly reduce maternal mortality rates, to ensure the presence of skilled attendants at 90 percent of deliveries, and to have all health facilities providing basic emergency obstetric care, all by the year 2015.²⁸⁸

²⁸⁴ Ministry of Health, “National Reproductive Health Policy,” 2007.

²⁸⁵ Ministry of Health, “National reproductive Health Policy,” p. 10.

²⁸⁶ Ministry of Public Health and Sanitation and Ministry of Medical Services, “National Reproductive Health Strategy, 2009-2015,” 2009, p.6.

²⁸⁷ *Ibid.*, pp. 9 and 17.

²⁸⁸ *Ibid.*, pp. 65-70.

National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya

In 2007, the Ministry of Medical Services and Ministry of Public Health and Sanitation developed the MNH Road Map, “To accelerate the reduction of maternal and newborn morbidity and mortality towards the achievement of the Millennium Development Goals (MDGs).”²⁸⁹ It has three objectives: to “[i]mprove data management for decision making and utilisation in health planning,” to “increase the availability, accessibility, acceptability, and utilisation of skilled attendance during pregnancy, childbirth and the post partum period at all levels of the health care system,” and to “strengthen the capacity of individuals, families, communities, social networks to improve maternal and newborn health.” The Road Map identifies obstetric fistula as a big problem and indicator of poor maternal health services but does not explicitly address fistula in its strategies.

Standards for Maternal Care in Kenya

These standards were developed by professional bodies (National Nurses Association of Kenya and the Kenya Obstetricians and Gynaecologists Society). They provide guidelines for handling emergency obstetric cases with the hope that “improved quality of care will increase clients’ satisfaction as well as ... use of services and thus help to reduce maternal and perinatal mortality and morbidity.”²⁹⁰ The section on management of women and girls who present with obstructed labor does not include important details, such as the need to insert an in-dwelling catheter, which can help with spontaneous closure of small fistulas.

Family Planning

Many policies and strategies on reproductive and maternal health address the importance of family planning in enhancing the health of women and children. The Family Planning Guidelines for Service Providers were first developed in 1991.²⁹¹ The guidelines were revised in 2005 to assist service providers in maintaining comprehensive care for clients seeking family planning, including the provision of youth-friendly services and linkage of family planning and HIV/AIDS services, and in 2010 to reflect the 2009 medical Eligibility Criteria of the World Health Organization.²⁹²

²⁸⁹ Ministry of Medical Services and Ministry of Public Health and Sanitation, “National Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Kenya,” March 2009, p. 13.

²⁹⁰ National Joint Steering Committee for Maternal Health Kenya, “Standards for Maternal Care in Kenya,” p. i.

²⁹¹ Ministry of Health, “Family Planning Guidelines for Service Providers,” March 2005.

²⁹² See Division of Reproductive Health, “National Guidelines for Service Providers,” 2010.

Adolescent Reproductive Health and Development Policy

Kenya has put in place an Adolescent Reproductive Health and Development Policy (ARH&D) policy to enhance the implementation and coordination of programs that address the reproductive health and development needs of young people. The policy addresses adolescent health issues such as sexual health and reproductive rights, harmful practices, drug and substance abuse, socio-economic factors, and the special needs of adolescents and young people with disabilities. Some of its targets are: to increase the proportion of facilities offering youth-friendly services to 85 percent, to reduce the proportion of women aged below 20 with a first birth from 45 percent in 1998 to 22 percent and to raise the median age of first sexual intercourse from 16.7 for girls and 16.8 for boys to 18 for both, all by 2015.²⁹³ The ARH&D Plan of Action 2005-2015 has been developed to guide implementation of the policy.²⁹⁴

Youth-Friendly Services

The National Guidelines for Provision of Youth-Friendly Services (YFS) in Kenya outlines the role of the health sector in addressing the special reproductive health concerns of young people.²⁹⁵ It outlines strategies, approaches, and models for delivery of YFS.

National Health Sector Strategic Plan and Kenya Essential Package for Health

Kenya's second National Health Sector Strategic Plan (NHSSP II – 2005–2010) defined a new approach to the way the sector will deliver health care services to Kenyans: the Kenya Essential Package for Health (KEPH). KEPH represents the integration of all health programs into a single package that focuses its interventions toward the improvement of health at different phases of the human development cycle. These phases represent various age groups or cohorts, each of which has special health needs. These services are provided at each of the six levels of the healthcare system.

²⁹³ National Council for Population and Development, Ministry of Planning and National Development/Department of Reproductive Health (DRH), Ministry of Medical Services, "Adolescent Reproductive Health and Development Policy," 2003, p.15.

²⁹⁴ DRH/NCAPD, "Adolescent Reproductive Health and Development Policy: Plan of Action 2005-2015."

²⁹⁵ DRH, "National Guidelines for Provision of Youth-Friendly Services (YFS) in Kenya," 2005.

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“I Am Not Dead, But I Am Not Living”

Barriers to Fistula Prevention and Treatment in Kenya

“This is a terrible illness. I thought I should kill myself. You can’t walk with people or travel. You can’t sleep comfortably or eat well. You can’t work because you are constantly in pain. You are always sad because you stain everything and you smell,” a 33-year-old woman who had lived with obstetric fistula for 17 years told Human Rights Watch.

Obstetric fistula is a preventable and treatable debilitating childbirth injury that leaves its victims constantly leaking urine and feces. Thousands of women and girls unnecessarily get fistula each year in Kenya, while many more are living with untreated fistula. This happens because of government failure to provide sufficient and well-resourced health facilities with the capacity to handle obstetric complications, to inform women that their condition can be treated, and the high cost of fistula repair.

The Kenya government has taken some positive steps to make pregnancy and childbirth safer for women. However, as this report shows through the voices of fistula survivors, the policy responses are not adequately reaching the women and girls they are supposed to help, and there is urgent need to reevaluate and scale-up many of the responses.

‘I Am Not Dead, But I Am Not Living’ finds that strengthening health system accountability— giving people accessible and effective ways of providing feedback, lodging complaints, providing redress, and ensuring that the feedback leads to improvements —can greatly enhance the health system by allowing the people it serves to tell the government what is working and what needs fixing. It also calls on the Kenyan government to develop and implement a national strategy on obstetric fistula.

Patients in a ward in Machakos General Hospital during a fistula repair camp.

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