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ACCELERATING THE GAINS OF THE FREE MATERNITY CARE IN KENYA'S URBAN INFORMAL SETTLEMENTS

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INTRODUCTION

Wanjiru lives in an informal settlement in the eastern part of Nairobi, Kenya.[1] She is in labor, about to give birth to her third child.[2] Like most women in this area, she goes to Pumwani public maternity hospital.[3] The hospital serves almost half of Nairobi residents.[4] While at the hospital she waits at the reception worried that a doctor has not come to examine her.[5] The nurses are overwhelmed by the many women they must attend to.[6] Wanjiru waits patiently for her turn. Finally, she is admitted in the wards.[7] Due to the large number of expectant women, some share beds while others sleep on the floor.[8] After a long and painful wait, the baby is born.[9] Wanjiru is exhausted.[10]

The above experience is shared by many pregnant women living in urban informal settlements, who depend on public health facilities

1. *See* Jayme Poisson, *Kenya New Life at an Old Hospital*, THE STAR (Nov. 27, 2011), https://www.thestar.com/news/world/2011/11/27/in_kenya_new_life_at_an_old_hospital.html [https://perma.cc/K7UG-K57B].
2. *See id.*; *see also* Emmanuel Mutisya & Masaru Yarime, *Understanding the Grassroots Dynamics of Slums in Nairobi: The Dilemma of Kibera Informal Settlements,* 2 INT'L TRANSACTION J. OF ENG'G, MGMT. & APPLIED SCI. & TECH. 197, 198 (2011), https://tuengr.com/V02/197-213.pdf [https://perma.cc/PL5Z-8KBJ].
3. *See* Poisson, *supra* note 1.
4. *See id.*; *see also* CTR. FOR REPRODUCTIVE RTS. & FED'N OF WOMEN LAWS, KENYA, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 7 (2006) [hereinafter FAILURE TO DELIVER], https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [https://perma.cc/7YST-38JC].
5. *See* Poisson, *supra* note 1.
6. *Id.*
7. *Id.*
8. *See* FAILURE TO DELIVER, *supra* note 4, at 48.
9. *See* Poisson, *supra* note 1.
10. *Id.*

for delivery of their babies.[11] Like Wanjiru, many poor pregnant women opt to utilize the available free maternity services.[12] For these women, the desire to deliver healthy babies surpasses the fear of pain and suffering during childbirth.[13] However, the free maternity services offered in many of the poorly equipped, congested and dilapidated public health facilities pose an existential danger to the precious lives of both the mother and their newborn babies.[14]

Urbanization has led to a population explosion that has put pressure on existing public health facilities, especially in Kenya's urban informal settlements.[15] Approximately seventy-one percent of urban dwellers live in informal settlements that have limited access to clean water, sanitation, health care, schools and other social services.[16] Women make up a growing portion of the population in the urban informal settlements.[17] Despite achievements in improving maternal health outcomes in Kenya, mortality rates in the informal settlements have remained high.[18]

The free maternity services, which were launched by the president of Kenya in 2013, have tremendously increased facility-based deliveries in Kenya's urban informal settlements.[19] The hurried implementation of the free maternity services program was not accompanied by any supportive mechanisms to increase the capacity of the existing public health facilities.[20] The free maternity services were aimed at reducing maternal mortality and improving maternal health

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11. *See* FAILURE TO DELIVER, *supra* note 4, at 7, 12.

12. *See* Poisson, *supra* note 1; *see also* FAILURE TO DELIVER, *supra* note 4, at 16, 54.

13. *See* Poisson, *supra* note 1.

14. *See* FAILURE TO DELIVER, *supra* note 4, at 9.

15. *See* U.N. Population Div., *World Urbanization Prospects: The 2001 Revision: Data Tables & Highlights,* at 1, U.N. DOCS. ESA/P/WP.173 (Mar. 20, 2002).

16. *See* Catherine Kyobutungi, Abdallah Kasiira Ziraba, Alex Ezeh & Yazoumé Yé, *The burden of disease profile of residents of Nairobi's slums: Results from a Demographic Surveillance System*, 6 POPULATION METRICS, Mar. 2008, at 1, 2, 8 n.2, https://pophealthmetrics.biomedcentral.com/track/pdf/10.1186/1478-7954-6-1 [https://perma.cc/JTM3-CBX3].

17. *See* CTR. ON HOUSING RTS. & EVICTIONS: WOMEN & HOUSING RTS. PROGRAMME, WOMEN, SLUMS, AND URBANISATION: EXAMINING THE CAUSES AND CONSEQUENCES 107 (2008); *see also* Mutisya & Yarime, *supra* note 2, at 198.

18. *See* Monica Akinyi Magadi, Eliya Msiyaphazi Zulu & Martin Brockerhoff, *The Inequality of Maternal Healthcare in Urban Sub-Saharan Africa in the l990s*, 57 POPULATION STUD. 347, 348 (2003).

19. *See* Lukoye Atwoli, *Free Maternity Keeps Uhuru & Ruto Health Pledge*, NATION (April 10, 2014), https://www.nation.co.ke/news/Free-maternity-keeps-Uhuru-and-Ruto-health-pledge/1056-2273820-xa81aqz/index.html [https://perma.cc/LL7L-E4TS].

20. *See* Eric Tama, Sassy Malyneux, Evelyn Waweru, Benjamin Tsofa, Jane Chuma & Edwine Barasa, *Examining the Implementation of The Free Maternity Services Policy In Kenya: A Mixed Methods Process Evaluation*, 6 INT'L J. HEALTH POL'Y & MGMT. 603, 606–07 (2017), https://www.ijhpm.com/article_3440_cca2ad9a33d3c4744010470311ecee2d.pdf [https://perma.cc/SKH4-4TG2].

outcomes by encouraging facility-based deliveries under skilled health personnel.[21] The increased demand for the free maternity services has put a strain on the existing medical facilities, supplies and skilled health personnel.[22] This strain on public health facilities has compromised the quality of health care provided.[23] The successful implementation of the free maternity services program has been hampered by inadequate medical facilities, understaffing and inadequate medical supplies.[24]

The 2010 Constitution of Kenya recognizes the special group of women living in urban informal settlements,[25] and provides for their access to the highest attainable standards of health care, including reproductive health care.[26] The Health Act, which was enacted in 2017, recognizes the significant challenges of accessing maternal health services among the poorest populations.[27] Pursuant to the resolutions of the African Union,[28] the Health Act abolished user fees for pregnant women.[29] The Health Act instructs the county and national governments to expand free maternity care and childhood immunizations through funding.[30] Despite Kenya's commitment to increase the national budget for health care to 15% of the gross domestic product (GDP),[31] the budgetary allocation for free maternity services has not increased over the years.[32]

Therefore, for the Health Act provision requiring free maternity care to be meaningful for women living in urban informal settlements,

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21. *See* Emanuel Wekesa Wamalwa, *Implementation Challenges of Free Maternity Services Policy in Kenya: The Health Workers' Perspective,* 22 PAN AFR. MED. J., Dec. 2015, at 2, 4 n.2, https://www.panafrican-med-journal.com/content/article/22/375/pdf/375.pdf [https://perma.cc/SMY5-S39U].

22. *Id.* at 3.

23. *See* Jonah M. Mwangi, Effect of The Free Maternity Programme On the Access and Outcomes of Maternal and Newborn Health (Mnh) In the County of Kiambu at 23–24 (2017) (M.B.A. thesis, United States International University Africa) (on file with the author).

24. Wamalwa, *supra* note 21, at 4.

25. CONSTITUTION art. 56 (2010) (Kenya).

26. *Id.* art. 43 (1)(a).

27. *See* The Health Act, No. 21 (2017), KENYA GAZETTE SUPPLEMENT No. 101 § 68.

28. Assembly of the African Union, *Actions on Maternal, Newborn & Child Health & Development*, at 1–3 ASSEMBLY/AU/DECL.1(XI) (July 25–27, 2010), http://www.who.int/pmnch/events/2010/AUassemblydec_e.pdf [https://perma.cc/ACM4-6QFS].

29. *See* The Health Act § 86.

30. *See id.* § 5(3)(b).

31. *See* WHO, THE ABUJA DECLARATION: TEN YEARS ON 2 (2010), https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1 [https://perma.cc/R8VD-UJWK].

32. *See* DEVELOPMENT INITIATIVES, ANALYSIS OF KENYA'S BUDGET 2017/18: WHAT'S IN IT FOR THE POOREST PEOPLE? 5 (2017), http://devinit.org/wp-content/uploads/2017/03/analysis-of-Kenyas-budget-2017-18-what%E2%80%99s-in-it-for-the-poorest-people.pdf [https://perma.cc/E5V5-XVP3].

and improve their birth outcomes, the county and national governments must increase funding for basic medical facilities, essential health supplies and staffing needs in these areas.[33] There are currently no adequate legal and policy frameworks for increasing maternal health care funding and accelerating the impact of the free maternity services program on maternal health outcomes in Kenya's urban informal settlements.[34]

In this Article, I propose that the national and county governments must increase funding for basic medical facilities, supplies and staffing at the county level to improve maternal health outcomes for the women living in urban informal settlements. The first part of this Article will describe the current state of the urban informal settlements. The second part will examine the state of maternal health care in Kenya's urban informal settlements. The third part will explore the governance structure for implementing the right to maternal health care in Kenya. The fourth part will explore the existing legal frameworks that promote the right to maternal health care in Kenya. The fifth part will provide recommendations for improving maternal health care in Kenya's urban informal settlements.

I. OVERVIEW OF THE URBAN INFORMAL SETTLEMENTS IN KENYA

A. The Rise of Urban Informal Settlements in Kenya

Informal settlements in Kenya have existed since the pre-independence era.[35] Segregation policies during the colonial era led to the growth of urban centers that were used as centers of administrative and political control.[36] A rapid increase in urban population during post-independence Kenya greatly challenged the growing urban economies.[37] The most rapid growth of informal settlements followed the attainment of independence in 1963.[38] Many informal

33. *Id.* at 16–17.

34. *See* Tama et al., *supra* note 20, at 612.

35. *See* Daniel Njoroge Githira, Growth and Eviction of Informal Settlements in Nairobi 2 (Feb. 2016) (M.Sc. thesis, University of Twente) (on file with author).

36. *See* Florence Dafe, *No Business like Slum Business? The Political Economy of the Continued Existence of Slums: A case study of Nairobi* 14 (Dev. Studies Inst., Working Paper No. 09-98, 2009), https://pdfs.semanticscholar.org/73bd/5c95a5bc028d08b71fa5637b6435f2cf9c6f.pdf [https://perma.cc/S4FW-YCMM].

37. *See* AMNESTY INT'L, AMNESTY INTERNATIONAL 2009 REPORT: THE STATE OF THE WORLD'S HUMAN RIGHTS 2–3 (2009), https://www.amnesty.org/download/Documents/48000/pol100012009en.pdf [https://perma.cc/ZD6M-GL25].

38. *See* Graham Alder, *Tackling Poverty in Nairobi's Informal Settlements: Developing an Institutional Strategy*, 7 ENV'T & URBANIZATION 85, 86 (1995), https://journals.sagepub.com/doi/pdf/10.1177/095624789500700203 [https://perma.cc/BF3N-4APG].

settlements were located on colonial settlers' farms, undeveloped land near farms, idle government or city council land and private land.[39] Poor planning and inadequate urban development policies led to the inability of the government to cope with the increasing demand for essential services such as housing, health, and education.[40] This resulted in the rapid rise of informal settlements in post-independent Kenya.[41] The informal nature of these settlements has contributed to neglect in terms of infrastructure development and other social services.[42] The government has failed to control expansion of these informal settlements, particularly in Nairobi, resulting in their proliferation.[43] The dynamic environment in many urban centers greatly impacts the health of its inhabitants.[44]

The acceleration of urbanization has been accompanied by an equally alarming increase in urban poverty.[45] Half of Nairobi city's population resides in the informal settlements.[46] These informal settlement dwellers live in abject poverty and lack basic amenities including proper housing, access to clean water and sanitation, education and essential health services.[47] The majority of women living in the informal settlements are young and lack formal education.[48] These women work in the informal sector and are socially and economically disadvantaged compared to their counterparts living in the rural area.[49]

The living standards vary from one informal settlement to the other.[50] This variation is dependent on various factors including the following: age of the informal settlement, type of land ownership, geographical location of the settlement, vitality of the informal settlement

39. *See* Githira, *supra* note 35, at 2.
40. *Id.* at 15.
41. *Id.* at 3.
42. *See* Kyobutungi et al., *supra* note 16, at 2.
43. *See* Githira, *supra* note 35, at 7.
44. *See* Jason Corburn & Irene Karanja, *Informal Settlements and a Relational View of Health in Nairobi, Kenya*: *Sanitation, Gender and Dignity*, 31 HEALTH PROMOTION INT'L 258, 258 (2016), https://static1.squarespace.com/static/591a33ba9de4bb62555cc445/t/591bab03e4fcb593c2670c57/1494985476114/corburn_karanja_2014_informal_settlements_%2B_health_hpi.pdf [https://perma.cc/H3CE-L2JV].
45. *Id.* at 259.
46. *See* Githira, *supra* note 35, at 1.
47. AMNESTY INT'L, *supra* note 37, at 2–3.
48. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., POPULATION AND HEALTH DYNAMICS IN NAIROBI'S INFORMAL SETTLEMENTS: REPORT OF THE NAIROBI CROSS-SECTIONAL SLUMS SURVEY (NCSS) 2000, at xv (2002), https://aphrc.org/wp-content/uploads/2018/11/Report-The-Nairobi-Cross-sectional-Slums-Survey-NCSS-2000-1.pdf [https://perma.cc/WU7Y-MQTF].
49. *Id.* at xviii.
50. *Id.*

and access to salaried employment of the dwellers.[51] Discriminatory policies in the colonial era,[52] post-independence policies of slum clearance, inequitable land ownership and distribution, and the urban development policies have also contributed to the present state of Nairobi's informal settlements.[53]

B. Characteristics of Urban Informal Settlements in Kenya

1. Inadequate Infrastructure

The informal settlements in Nairobi have faced several decades of marginalization by the government.[54] These informal settlements have been left out from Nairobi City's planning and budgetary considerations.[55] The previous and current administrations have ignored the existence of these settlements until recently, when national authorities and international organizations outlined the dangers posed by the squalor living conditions in the informal settlements.[56] The dynamics of the urban informal settlements have made it burdensome for the government to pass effective policies that would improve the living conditions in these settlements.[57] The persistent disregard for these settlements has also deprived the dwellers of essential services that should be provided by their government.[58] These essential services include clean water supply,[59] adequate sanitation, electricity, garbage collection, essential health services, education, and transport and road networks.[60] Inadequate access to these essential services poses serious health risks to the dwellers.[61] Ineffective leadership and lack of political will has contributed to the worsening of the plight of inhabitants in these settlements.[62] Over the years, Kenya's urban areas have suffered from poor planning

51. *See* Alder, *supra* note 38, at 102.

52. *See* WINNIE MITULLAH, THE CASE OF NAIROBI, KENYA 10 (2003), https://www.ucl.ac.uk/dpu-projects/Global_Report/pdfs/Nairobi.pdf [https://perma.cc/M8XY-XWSN].

53. *See* Leah Muraguri, *Kenyan Government Initiatives in Slum Upgrading*, 44 LES CAHIERS D'AFRIQUE DE L'EST 119, 119 (2011), https://journals.openedition.org/eastafrica/pdf/534 [https://perma.cc/9YMR-HRXQ].

54. *See* Mutisya & Yarime, *supra* note 2, at 198.

55. *Id.* at 201.

56. *Id.* at 200.

57. *Id.* at 201.

58. *Id.*

59. *See* STACY HARRIS, FOUND. FOR INT'L CARDIAC & CHILDREN'S SERVS., HEALTH REPORT: YOUNG WOMEN AND GIRLS IN THE SLUMS OF KENYA 8 (2011), https://www.slideshare.net/StacyHarris1/ficcs-health-report [https://perma.cc/K2UD-62G4].

60. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 17.

61. *See* Mutisya & Yarime, *supra* note 2, at 200.

62. *Id.* at 201.

and mismanagement of resources that have resulted in the explosion of informal settlements with poor housing and insignificant or no infrastructure services.[63] While urbanization may influence the overall health and living standards in the community, the urban explosion may render the government unable to provide basic facilities and essential services, as well as employment opportunities to match the emerging needs.[64]

2. High Unemployment

The population explosion in the urban areas, resulting from the rural-urban migration, has led to high unemployment rates in the informal settlements.[65] The majority of the informal settlement dwellers work in the informal sector with unstable income, or engage in small-scale, income-generating activities with dwindling income.[66] Many more are unemployed and may engage in criminal activities and other social vices.[67] Unemployment is high among the women,[68] who are potentially vulnerable to many social vices.[69] Many women living in the urban informal settlements may engage in social vices, out of desperation, and as a means of survival in the highly competitive urban area.[70]

3. Insecurity

Insecurity and the meagre income from the informal sector make women living in informal settlements exceptionally vulnerable to violence and other criminal activities, both as victims and perpetrators.[71] The informal settlements potentially harbor criminals.[72] The government's security apparatus rarely patrol the informal settlements, which provide a haven for many criminal gangs.[73]

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63. *Id.* at 198.
64. *Id.* at 210.
65. *Id.* at 198.
66. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 16–17.
67. *See id.* at 147.
68. *See* Bernard Munyao Muiya, *The Nature, Challenges and Consequences of Urban Youth Unemployment: A Case of Nairobi City, Kenya*, 2 UNIVERSAL J. EDUC. RSCH. 495, 497 (2014), https://files.eric.ed.gov/fulltext/EJ1053917.pdf [https://perma.cc/HTP4-2CRY].
69. *See id.*
70. *See* PHILISTA ONYANGO & ARNE TOSTENSEN, CHR. MICHELSEN INST., THE SITUATION OF YOUTH AND CHILDREN IN KIBERA 2 (2015), https://www.cmi.no/publications/file/5527-the-situation-of-youth-and-children-in-kibera.pdf [https://perma.cc/2C2S-Q6PK].
71. *Id.* at 3.
72. *See id.* at 21.
73. *See* Patrick Mutahi, *Between Illegality and Legality: (In)security, Crime, and Gangs in Nairobi Informal Settlements*, 37 CRIME Q. 11, 11–12 (2011).

4. Poverty

Half of the population in the urban informal settlements lives in abject poverty and squalor living conditions.[74] Poverty, which was largely associated with the rural population, has been recognized as an urban challenge.[75] The quality of life in the urban informal settlements is actually worse than in the rural areas.[76] The urban poor, especially those living in informal settlements, are likely to have less access to the health services, and therefore demonstrate higher mortality rates than their rural counterparts.[77] Furthermore, the poor environmental factors expose them to avoidable health hazards.[78]

5. Low Levels of Education and Health Awareness

Lack of access to quality health information and services may be a critical intermediate determinant of health for the informal settlers.[79] Urbanization, and the ensuing unemployment, has been associated with inadequate acquisition of knowledge and skills from formal training.[80] Lower literacy levels may result in poor health status and subsequently interfere with schooling.[81] Ill health, physical and mental disabilities, and unhealthy lifestyles may all have a deleterious effect on educational outcomes.[82] Education can create opportunities for improved health outcomes, whilst poor health can jeopardize educational achievements.[83] Low standards of education in many urban informal settlements may result in low levels of health awareness and understanding, which underpins the poor health outcomes that may be observed in many vulnerable populations.[84] Health awareness and understanding may influence access to

74. *See* Wendy Taylor & Harrison Maithya, *Urban Families under Pressure in Kenya and the Impact of HIV/AIDS* 12, 20 (Univ. Birmingham Int'l Dev. Dep't, Working Paper No. 2, 2007).

75. *Id.* at 12–13.

76. *Id.*

77. *Id.* at 13.

78. *Id.*

79. *See* WHO KOBE CENTRE, A BILLION VOICES: LISTENING AND RESPONDING TO THE HEALTH NEEDS OF SLUM DWELLERS AND INFORMAL SETTLERS IN NEW URBAN SETTINGS 7 (2005), https://www.who.int/social_determinants/resources/urban_settings.pdf?ua=1 [https://perma.cc/EU94-KMKB].

80. *See* Muiya, *supra* note 68, at 495–96.

81. *See* Phyllis Easton, Vikki A. Entwistle & Brian Williams, *Health in the 'Hidden Population' of People with Low Literacy*, 10 BIOMED CENT. PUB. HEALTH, Aug. 2010, at 6–8.

82. *See* Anne Case, Angela Fertig & Christina Paxson, *The Lasting Impact of Childhood Health and Circumstance*, 24 J. HEALTH ECON. 365, 371, 373 (2005).

83. *Id.* at 366.

84. *See* HARRIS, *supra* note 59, at 18.

health services and may motivate the use of health information to promote and maintain good health.[85] Basic health awareness and understanding may potentially help reduce individual vulnerability to health problems in the urban informal settlements.[86]

II. MATERNAL HEALTH CARE IN KENYA'S URBAN INFORMAL SETTLEMENTS

A. Challenges of Access to Maternal Health Care for Women Living in Informal Settlements in Kenya

Women living in urban informal settlements have continued to experience poorer health outcomes[87] than their counterparts in the formal settlements.[88] Urban informal settlements are characterized by high maternal morbidity and mortality rates.[89] The disparity in health outcomes between the urban poor and wealthy dwellers has been well described.[90] The urban informal settlement dwellers experience poorer health outcomes when compared with their rural counterparts.[91] Yet the plight of the urban poor has not received as much attention as their rural counterparts.[92] Poor understanding of the health challenges in the urban informal settlements resulting from inadequate data and ineffective measurement tools has contributed to the lack of adequate public policy frameworks to address health inequalities.[93] Ineffective local and national governance may also adversely affect advancement of the urban poor's health agenda.[94]

1. Access to Qualified Skilled Health Personnel

Although many maternal deaths occur inside formal health facilities, most of the deliveries and abortions which caused those

85. *See id.* at 18–19.

86. *Id.* at 19.

87. *See* Jacques Emina, Donatien Beguy, Eliya M. Zulu, Alex C. Ezeh, Kanyiva Muindi, Patricia Elug'ata, John K. Otsola & Yazoumé Yé, *Monitoring of Health and Demographic Outcomes in Poor Urban Settlements: Evidence from The Nairobi Urban Health and Demographic Surveillance System*, 88 J. URB. HEALTH 200, 201 (2011).

88. *See* Corburn & Karanja, *supra* note 44, at 259.

89. *See* CTR. FOR REPROD. RTS., THE KENYA NATIONAL COMMISSION ON HUMAN RIGHTS' SEXUAL AND REPRODUCTIVE RIGHTS PUBLIC INQUIRY REPORT: A CALL TO ACTION FOR THE KENYAN GOVERNMENT 5 (2013).

90. *See* Corburn & Karanja, *supra* note 44, at 259.

91. *See* Priya Shetty, *Health Care for Urban Poor Falls Through the Gap*, 377 LANCET 627, 627 (2011).

92. *Id.*

93. *Id.*

94. *Id.*

deaths occurred under the care of unskilled birth attendants.[95] That may indicate a potential delay in seeking appropriate care to deal with the emergent causes of maternal mortality.[96] Many of these deaths could have been prevented if poor pregnant women, particularly those living in urban informal settlements, had access to qualified skilled health care personnel and high-quality emergency obstetric care services.[97]

2. Access to Public Health Care Facilities

Most urban informal settlements in Kenya do not have adequate public health care facilities.[98] This has resulted in the mushrooming of poor quality privately owned health care facilities that lack appropriate equipment, supplies, and qualified skilled personnel to offer services to the poor women living in these settlements.[99] Many of these privately owned health care facilities that are located within the urban informal settlements are neither regulated nor licensed by the government.[100] The few privately owned facilities meeting minimum standards of care are likely beyond the reach of the urban poor women.[101] Accessing formal emergency obstetric care within urban centers, which is necessary when dealing with pregnancy complications, becomes an uphill task for most women residing in urban informal settlements.[102] The World Health Organization (WHO) recommends emergency obstetric care in cases of complications as an essential component for reducing maternal and neonatal mortality, especially in informal settlements.[103]

Poverty, level of education, ethnicity, and maternal parity greatly influence the use of skilled maternal health care services.[104] Increased

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95. *See* Abdhalah Kasiira Ziraba, Nyovani Madise, Samuel Mills, Catherine Kyobutungi & Alex Ezeh, *Maternal mortality in the informal settlements of Nairobi city: what do we know?*, 6 REPROD. HEALTH, Apr. 2009, at 7.

96. *Id.* at 6.

97. *Id.* at 7.

98. *See* ROSE N. ORONJE, AFRICAN POPULATION & HEALTH RSCH. CTR., THE MATERNAL HEALTH CHALLENGE IN POOR URBAN COMMUNITIES IN KENYA 1 (2009).

99. *Id.*

100. *Id.*

101. *See* Jean Christophe Fotso & Carol Mukiira, *Perceived Quality of and Access to Care Among Poor Urban Women in Kenya and Their Utilization of Delivery Care: Harnessing the Potential of Private Clinics?*, 27 HEALTH POL'Y AND PLAN 505, 512 (2011).

102. *Id.*

103. *See* WHO, WHO RECOMMENDATIONS ON ANTENATAL CARE FOR A POSITIVE PREGNANCY EXPERIENCE 55 (2016), https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en [https://perma.cc/F3YM-2ARL].

104. *See* Martin K. Mutua, Elizabeth Kimani-Murage & Remare R. Ettarh, *Childhood*

utilization of maternal health care services for pregnant mothers living in informal settlements diminishes the likelihood of complications during and immediately after delivery.[105] In Kenya, poor women risk exhausting their limited economic resources while seeking health care in public hospitals.[106] Facilities that lack proper licensing are illegal and offer substandard services.[107] Limited access to basic health care services may significantly contribute to the low immunization coverage for many women living in informal settlements.[108]

3. Antenatal and Post-natal Care Coverage

A great challenge facing many expectant women living in urban informal settlements relates to how soon they visit a health facility after discovering that they were expectant.[109] The commencement of antenatal care (ANC) visits essentially links identification of high risk pregnancies to adequate management of complications arising from them.[110] Initial ANC visits are very important because they ensure that the mother enjoys the full benefits of being cared for by skilled health personnel.[111] Early ANC visits may be linked to lower maternal mortality rates.[112] This is especially important because many women in urban informal settlements potentially die due to preventable causes.[113]

The WHO recommends at least eight antenatal visits and skilled health care during and immediately after delivery to potentially reduce maternal and perinatal mortalities.[114] The WHO also recommends emergency obstetric care in cases of complications as a key to reducing maternal and neonatal mortality, especially in informal settlements.[115] The costs for antenatal/postnatal care and skilled delivery are simply too high for many poor women in Kenya,

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Vaccination in Informal Urban Settlements in Nairobi, Kenya: Who Gets Vaccinated?, 11 BIOMED CENT. PUB. HEALTH, 2011, at 9.

105. *See* Tama et al., *supra* note 20, at 604.

106. *See* Chimaraoke O. Izugbara, Caroline W. Karibu & Eliya M. Zulu, *Urban Poor Kenyan Women and Hospital-Based Delivery*, 124 PUB. HEALTH REPS. 585, 587–88 (2009).

107. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., HEALTH AND LIVELIHOOD NEEDS OF RESIDENTS OF INFORMAL SETTLEMENTS ON NAIROBI CITY 6 (2002).

108. *See* Edith Miguda, *The Distant Big Hospital: Linking Development, Poverty and Reproductive Health—A Gender Mainstreaming Approach*, 16 WASH. & LEE J. CIV. RTS. & SOC. JUST. 113, 119 (2009).

109. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 97.

110. *Id.* at 103.

111. *Id.*

112. *Id.*

113. *Id.* at 102.

114. *See* WHO, *supra* note 103, at 105.

115. *See id.* at 97.

especially those living in urban informal settlements.[116] Kenya recommends that pregnant mothers make at least four ANC clinic visits during their pregnancies.[117] These visits should be spread across the trimesters.[118] This is in line with the global maternal health recommendations of visits at the first and last trimesters.[119] During these visits, the pregnant mothers receive the following: iron and folic acid supplements,[120] immunization against maternal and neonatal tetanus,[121] monitoring of blood pressure,[122] maternal weight,[123] protein in urine testing, and management of various infections such as HIV/AIDS and Syphilis.[124] Antenatal and post-natal care coverage has remained low in many urban informal settlements.[125]

4. Cost of Maternal Health Care

Access to maternal health care in urban informal settlements is also significantly influenced by the cost of services offered during pregnancy and at childbirth.[126] Abject poverty drives women to seek alternative and relatively affordable care that may not meet their needs.[127] Although WHO recommends at least eight antenatal visits and skilled health care during and immediately after delivery for women with uncomplicated pregnancies, only half of pregnant women in many urban informal settlements attend ANC at least once during their pregnancies.[128] A majority of pregnant women in informal settlements attend their first ANC visit in the last trimester of their pregnancy.[129] The cost of ANC care for many of these women continues to play a critical role in their health-seeking behaviors.[130] This

116. AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 102.
117. *Id.* at 105.
118. *Id.* at 103.
119. *See* Rhoune Ochako & Wanjiru Gichuhi, *Pregnancy Wantedness, Frequency and Timing of Antenatal Care Visit Among Women of Childbearing Age in Kenya*, 13 REPROD. HEALTH, 2016, at 2.
120. *See* WHO, *supra* note 103, at 95.
121. *Id.*
122. *See id.* at 85.
123. *See id.* at 106.
124. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 103.
125. *See id.* at 102.
126. *See* ORONJE, *supra* note 98, at 2.
127. *See* Jean-Christophe Fotso, Alex C. Ezeh & Hildah Essendi, *Maternal Health in Resource-Poor Urban Settings: How Does Women's Autonomy Influence the Utilization of Obstetric Case Services?*, 6 REPROD. HEALTH, June 2009, at 6.
128. *See* ORONJE, *supra* note 98, at 2.
129. *See* N. Ntui Asundep, April P. Carson, Cornelius Archer Turpin, Berhanu Tameru, Ada T. Agidi, Kui Zhang & Pauline E. Jolly, *Determinants of Access to Antenatal Care and Birth Outcomes in Kumasi, Ghana*, 3 J. EPIDEMIOLOGY & GLOB. HEALTH 279, 280 (2013).
130. *See id.* at 285.

financial cost leads to poor ANC coverage, which threatens to reverse many of the benefits of the Safe Motherhood Initiative.[131] User fees and mode of payment may also contribute to the plight of many urban poor pregnant women leading to their overall poor maternal health outcomes.[132] Although ANC services are free, many public health care facilities still charge for the patient's registration and for the laboratory tests recommended during the first ANC visit.[133] Women from poor households were more likely to go for fewer ANC visits with the first ANC visit later in the pregnancy.[134] Subsequently, many women in the informal settlements would give birth at home attended by traditional birth attendants.[135]

5. Reproductive Health Challenges

Kenya's urban informal settlements present a high-risk environment for the transmission and spread of HIV and other sexually transmitted infections.[136] The prevalence of HIV/AIDS in Kenya is higher in the urban slums than in the rest of the urban areas.[137] Poverty, unemployment, drug abuse, and alcohol abuse potentially expose many poor women to harmful sexual encounters.[138] Women form the majority of the inhabitants of urban informal settlements and suffer many reproductive health issues.[139] These vulnerable populations lack adequate facilities for progressive reproductive health.[140] The vulnerability of women presents an urgent need for adequate health care services, particularly for many poor women living in urban informal settlements who are at an increased risk of HIV/AIDS infection.[141] Environmental conditions in most of the urban

131. *See* MINISTRY OF HEALTH, STATUS OF IMPLEMENTATION OF FREE MATERNITY SERVICES PROGRAM IN THE DEVOLVED HEALTH SYSTEM IN KENYA 33 (2015).

132. *See* Linda Mason, Stephanie Dellicour, Feiko Ter Kuile, Peter Ouma, Penny Phillips-Howard, Florence Were, Kayla Laserson & Meghna Desai, *Barriers and Facilitators to Antenatal and Delivery Care in Western Kenya: A Qualitative Study*, 15 BIOMED CENT. PREGNANCY & CHILDBIRTH, 2015, at 8.

133. *See* Asundep et al., *supra* note 129, at 284.

134. *See* Ochako & Gichuhi, *supra* note 119, at 6.

135. *See* Izugbara et al., *supra* note 106, at 588.

136. *See* Eliya M. Zulu, F. Nii-amoo Dodoo & Alex Chika-Ezeh, *Sexual Risk-Taking in the Slums of Nairobi, Kenya, 1993–98*, 56 POPULATION STUDS. 311, 321–22 (2002).

137. *See* Nyovani J. Madise, Abdallah K. Ziraba, Joseph Inungu, Samuol A. Khamadi, Alez Ezeh, Eliya M. Zulu, John Kebaso, Vincent Okoth & Matilu Mwau, *Are Slum Dwellers at Heightened Risk of HIV Infection Than Other Urban Residents? Evidence from Population-Based HIV Prevalence Surveys in Kenya*, 18 HEALTH & PLACE 1144, 1148 (2012).

138. *See* Fredrick Mugisha & Eliya Msiyaphazi Zulu, *The Influence of Alcohol, Drugs and Substance Abuse on Sexual Relationships and Perception of Risk to HIV Infection Among Adolescents in The Informal Settlements of Nairobi*, 7 J. YOUTH STUD. 279, 280–81 (2004).

139. *See* Madise et al., *supra* note 137, at 1146.

140. *See* Miguda, *supra* note 108, at 117–18.

141. *See* HARRIS, *supra* note 59, at 11–12.

informal settlements are also potentially hazardous to the health of its inhabitants.[142]

Unsafe abortions are a major and preventable cause of maternal morbidity and mortality in Kenya's urban informal settlements.[143] Many of these women have had their sexual debut in their tender years.[144] The majority of them may engage in prostitution and may procure abortions due to the resultant unwanted pregnancies.[145] Lack of safe abortion laws in Kenya has steered women to seek services from unskilled personnel, who use unorthodox methods of procuring abortion.[146]

B. Maternal Mortality in Kenya's Informal Settlements

1. Statistics on Maternal Mortality in Informal Settlements

Maternal mortality has been defined as the death of a woman while pregnant or within forty-two days of terminating a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management.[147] There are gaps in maternal mortality indicators between the urban wealthy and poor women living in the informal settlements.[148] Kenya's urban informal settlements experience higher maternal death rates than the rest of the urban centers (706 versus 510 maternal deaths per 100,000 live births, respectively).[149] The high number of maternal deaths in the urban informal settlements reflects the inequities in access to health services and highlights the gap between the urban rich and poor women living in the informal settlements.[150] Most of these deaths could have been averted if the pregnant women had access to appropriate maternal health care, including antenatal and delivery care.[151]

The introduction of the free maternity services in Kenya improved the maternal health indicators in the urban informal settlements.[152]

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142. *See* Corburn & Karanja, *supra* note 44, at 267.

143. *See* KENYA NAT'L COMM'N ON HUM. RTS., REALISING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR REALITY? A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA 46–47 (2012).

144. *See* ONYANGO & TOSTENSEN, *supra* note 70, at 3.

145. *Id.* at 22.

146. *See* KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 47.

147. *See* WHO, MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY WHO, UNICEF, AND UNFPA 3 (2004)

148. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 102.

149. *See* Ziraba et al., *supra* note 95, at 5.

150. *See* Maternal Mortality Factsheet, WHO (2019), https://www.who.int/news-room/fact-sheets/detail/maternal-mortality [https://perma.cc/8FQM-49HZ].

151. *See* WHO, *supra* note 147, at 14.

152. MINISTRY OF HEALTH, HEALTH SECTOR WORKING GROUP REPORT 20 (2016).

The health facility deliveries increased from 54.3% to 83%, and the skilled birth attendance increased from 52.3% to 82.6%.[153] However, given the overwhelming poverty and the poorly equipped and understaffed public health facilities in the urban informal settlements, the maternal mortality situation is expected to deteriorate in these areas compared to the rest of the urban centers.[154] A majority of the women living in the urban informal settlements do not enjoy the urban advantage of maternal health care and may still register high rates of maternal mortality.[155] Without adequate funding and specific policies for implementing the free maternity care, the gains in maternal health indicators may not be sustainable in the urban informal settlements.[156] The existing inequalities can only be expected to worsen.[157]

2. Factors Contributing to Maternal Mortality in the Urban Informal Settlements

Maternal mortality in the urban informal settlements results from the interplay of socioeconomic and cultural barriers, combined with a high fertility rate that often leads to population explosion.[158] These barriers influence the maternal health indicators, including postnatal and antenatal coverage.[159] Most maternal deaths are due to causes directly related to pregnancy and childbirth,[160] and include unsafe abortions and obstetric complications such as severe bleeding, infection, hypertensive disorders, and obstructed labor.[161] Most of these complications can be managed if they are detected early during the subsistence of the pregnancy.[162] The health inequities affecting the urban poor women arise from the socioeconomic and political

153. *See* C.M. Gitobu, P.B. Gichangi & W.O. Mwanda, *The effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities*, 18 BMC PREGNANCY & CHILDBIRTH, 2018, at 4–5, https://doi.org/10.1186/s12884-018-1708-2 [https://perma.cc/JK8Q-5TAT].

154. *See* Jonah M. Mwangi, Effect of The Free Maternity Programme On the Access and Outcomes of Maternal and Newborn Health (Mnh) In the County of Kiambu 21–22 (Spring 2017) (MBA thesis, U.S. Int'l Univ. Afr.) (on file with author).

155. *See* AFRICAN POPULATION & HEALTH RSCH. CTR., *supra* note 48, at 111.

156. *See* Mwangi, *supra* note 154, at 22, 53.

157. *See* OXFAM, URBAN POVERTY AND VULNERABILITY IN KENYA: THE URGENT NEED FOR CO-ORDINATED ACTION TO REDUCE URBAN POVERTY 2 (2009), https://reliefweb.int/sites/reliefweb.int/files/resources/AB7F36D6785194D3432576470033317B-Full_Report.pdf [https://perma.cc/NDK4-9NBK].

158. *See* CTR. FOR REPROD. RTS., *supra* note 89, at 5.

159. *Id.*

160. *See* Maternal Mortality Factsheet, *supra* note 150.

161. *See* Ziraba et al., *supra* note 95, at 3–4.

162. *See* WHO, MATERNAL AND CHILD HEALTH: KENYA 1–2 (2011), https://www.who.int/pmnch/media/membernews/2011/20121216_kenyaparliament.pdf [https://perma.cc/CG4S-H3EZ].

inequalities characterizing many of the urban informal settlements.[163] Women with a higher education are much more likely to receive antenatal care from a qualified medical doctor than are those with no education.[164]

The restrictive abortion legislation also contributes substantially to the high maternal mortality in Kenya's urban informal settlements.[165] Maternal mortality related to unsafe abortion rates tend to be highest in urban informal settlements.[166] Under the Constitution of Kenya, abortion is allowed only in restricted circumstances.[167] Procuring or aiding the procurement of abortion in Kenya is an offense punishable by imprisonment.[168] Although the Ministry of Health issued guidelines that clarified circumstances when abortion was permitted, these guidelines were withdrawn due to political pressure from many religious groups.[169] Therefore, in the absence of guidelines, women in Kenya continue to turn to unsafe procedures by unskilled practitioners.[170] Complications from unsafe abortions may account for one third of maternal deaths in Kenya.[171]

III. THE GOVERNANCE STRUCTURE FOR IMPLEMENTATION OF MATERNAL HEALTH RIGHTS IN KENYA

A. National Government of Kenya

1. The Parliament of Kenya

The bicameral law-making organ of Kenya, consisting of both the Senate and the National Assembly,[172] represents the will of the people of Kenya, including the vulnerable populations.[173] This law-making organ is fundamental to the development of health laws and resolution

163. *See* Alder, *supra* note 38, at 103–04.
164. *See* WHO, *supra* note 162, at 2–3.
165. *See* Miguda, *supra* note 108.
166. *See* NICOLE BOURBONNAIS, KENYA NAT'L COMM'N ON HUM. RTS., IMPLEMENTING FREE MATERNAL HEALTH CARE IN KENYA: CHALLENGES, STRATEGIES, AND RECOMMENDATIONS 8–9 (2013).
167. CONSTITUTION art. 26 (4) (2010) (Kenya).
168. Penal Code (2012) Cap. 63 §§ 158–160 (Kenya).
169. *See* Joyce Chimbi, *Government Urged to Release 'Safe' Abortion Guidelines*, NATION (June 22, 2016), https://www.nation.co.ke/news/Govt-urged-to-release-safe-abortion-guidelines/1056-3261678-psus7rz/index.html [https://perma.cc/28DG-Q5SR].
170. *See* THE LAWYER'S CIRCLE, DECHERT LLP & OXFAM, IMPLEMENTING THE PROTOCOL ON THE RIGHTS OF WOMEN IN AFRICA: ANALYZING THE COMPLIANCE OF KENYA'S LEGAL FRAMEWORK 5–6 (2014), http://www.soawr.org/sites/default/files/ml-implementing-protocol-womens-rights-africa-010314-en.pdf [https://perma.cc/D37Q-BWAM].
171. *See* BOURBONNAIS, *supra* note 166, at 9.
172. CONSTITUTION art. 93(1) (2010) (Kenya).
173. *Id.* art. 94(2).

of issues that are critical to advancing the maternal health rights for all women, including those living in the urban informal settlements.[174] The legislators discuss and approve the national budgetary allocations for the implementation of the free maternity care services.[175] The Parliament holds the National Government of Kenya accountable for implementing the laws and policies touching on maternal health rights, especially for women living in the informal settlements.[176] Despite making laws, the Kenyan legislators can ensure that adequate financial resources are available to facilitate implementation of the free maternity services for all women.[177] These financial resources may improve the overall status of women in Kenya by ensuring access to quality maternal health care among the poor women living urban informal settlements.[178] The Constitution recognizes women living in the urban informal settlements as a special group needing protection.[179]

The Parliament also develops the legal frameworks used to address gender inequality regarding access to adequate health resources.[180] These frameworks seek to address the widening gender disparities in overall health status.[181] The Members of Parliament represent the will of all the people of Kenya, including vulnerable populations.[182] Therefore, they have a role to play in ensuring that the peculiar needs of marginalized women are enshrined in national development strategies.[183] They may pass legislation that seek to increase spending on women's health or amend laws to ensure equity in resource allocation and efficiency in resource utilization.[184]

The Senate serves the interest of the Kenyan people at the county level.[185] Senators have the obligation and mandate to makes laws that govern operations at the county level.[186] The Senate also participates in the legislative function of the Parliament by approving Bills concerning counties.[187] The Constitution mandates the Senate to conduct its matters with transparency and publicity.[188] This

174. *See id.* art. 95(2).
175. *See* WHO, *supra* note 162, at 3–4.
176. CONSTITUTION art. 95(4)(c) (2010) (Kenya).
177. *Id.* art. 95(4).
178. *See* WHO, *supra* note 162, at 3–4.
179. CONSTITUTION art. 56 (2010) (Kenya).
180. *See* WHO, *supra* note 162, at 3–4.
181. *See id.*
182. CONSTITUTION art. 95 (2010) (Kenya).
183. *See* WHO, *supra* note 162, at 3–4.
184. CONSTITUTION art. 95(4)(b) (2010) (Kenya).
185. *Id.* art. 96(1).
186. *Id.* art. 96(1)–(4).
187. *Id.* art 96(2).
188. *Id.* art. 118.

provides an opportunity for public participation and oversight in the law-making process, particularly on matters that affect their everyday lives.[189] The Senate proceedings are open to members of the public as well as the media.[190] Individual members of the public, civil society, as well as human rights organizations may petition the county assemblies to consider formulating or amending laws that seek to advance maternal health rights within the county boundaries.[191]

2. The Role of the Executive in Relation to Maternal Health Care

The Constitution of Kenya mandates the executive arm of the Government of Kenya to ensure its citizens enjoy all the rights and fundamental freedoms in the Bill of Rights, including the right to health.[192] The executive is further required to formulate policies and set standards to facilitate progressive realization of these rights and freedoms.[193] The state organs are expected to address the needs of the vulnerable groups within the society, and to protect their rights and freedoms as enshrined in the Constitution.[194] The state is expected to enact legislation for the implementation of its obligations under the ratified international instruments on fundamental rights and freedoms.[195] The Constitution considers treaties, conventions, and international instruments ratified by Kenya as part of the law.[196] It is important to note that the state has a significant role to play in ensuring realization and implementation of the constitutional provisions on maternal health rights for women living in the informal settlements.[197]

3. The Role of the Judiciary in Relation to Maternal Health Care

The judicial authority in Kenya is derived from the people and is vested in, and exercised by, the courts and tribunals established under the Constitution.[198] Therefore, parties can move to the courts

189. *Id.*
190. CONSTITUTION art. 118(2) (2010) (Kenya).
191. *Id.* art. 119.
192. *Id.* art. 21(1).
193. *Id.* art. 21(2).
194. *Id.* art. 21(3).
195. *Id.* art. 21(4).
196. *See* CONSTITUTION art. 21(4) (2010) (Kenya).
197. *See id.* art. 21(3).
198. *Id.* art. 1(1), (3)(c).

to seek interpretation of the law or compel the government to implement the provisions of the Bill of Rights.[199] The judiciary is mandated to interpret and apply the laws in Kenya.[200] The courts and tribunals are mandated to ensure the attainment of access to justice for all, irrespective of their status.[201]

The High Court of Kenya has a specific constitutional mandate and power to determine applications seeking to redress denial, violation or infringement of, or a threat to, a right or fundamental freedom in the Bill of Rights,[202] including maternal health rights.[203] The High Court may make an affirmation of these rights, issue an injunction to stop violation of these rights,[204] or make a declaration of illegality of any law, policy, or any other instrument that facilitates the denials, violations, and infringements or threatens the right to health.[205] The High Court may also issue an order of compensation in some instances.[206] Therefore, individuals and stakeholders representing vulnerable women in the urban informal settlements may bring cases before the High Court seeking an interpretation of the law or a remedy for violation of their right to maternal health care.[207]

The Constitution of Kenya also establishes constitutional commissions and independent offices.[208] These bodies seek to protect the sovereignty of the people and ensure observance, by all state organs, of the values and principles of the Constitution.[209] The Kenya National Commission on Human Rights (KNCHR),[210] the National Gender and Equality Commission (NGEC), and the Commission on Administrative Justice (CAJ) play different roles in monitoring the implementation of human rights and administrative justice in Kenya.[211] These three commissions are mandated to provide an oversight on matters relating to human rights abuses.[212] The NGEC is particularly mandated to work with other relevant institutions in developing the standards for the implementation of policies that will

199. *Id.* art. 20.
200. *See id.* art. 159.
201. *Id.* art. 159 (2)(a).
202. CONSTITUTION art. 23(1), 165(3)(b) (2010) (Kenya).
203. *See id.* art 23(1).
204. *Id.* art. 23(3)(b).
205. *Id.* art. 23(3)(d).
206. *Id.* art. 23(3)(e).
207. *See id.* art. 22(1)–(2).
208. *See* CONSTITUTION art. 248–54 (2010) (Kenya).
209. *Id.* art. 249(1).
210. *Id.* art. 59(1)–(2).
211. *Id.* art. 249; *see About the National Gender and Equality Commission*, NAT'L GENDER & EQUAL. COMM'N (2020), https://www.ngeckenya.org/home/about [https://perma.cc/J2DM-9NAA].
212. *See* CONSTITUTION art. 249(1) (2010) (Kenya).

ensure the progressive realization of social and economic rights, including the right to maternal health care.[213]

B. The Role of the County Assembly in Implementation of the Free Maternity Care

The Constitution of Kenya provides for a devolved system of governance.[214] This system of governance integrates the principles of devolution and access to justice into the Kenyan system of governance.[215] Devolution is one of the national values and a principle of governance that must be adhered to by any state organ, state officer, public officer, and all persons.[216] The different levels of government under the devolved system have distinct functions that are outlined in the fourth schedule of the Constitution.[217]

The provision of health services is one of the devolved functions in Kenya.[218] The county governments must comply with the national policies and standards set to achieve appropriate health service delivery at the county level.[219] However, the devolved public health care system has been criticized for the inequalities in health services delivery.[220] It is important that the different actors at the two levels of government ensure accessibility of health resources for vulnerable populations, especially women living in the informal settlements.[221]

C. The Role of the Private Health Sector in Kenya

The private sector is increasingly emerging as an important partner in providing health services in Kenya.[222] Private hospitals, which may be either for-profit or not-for-profit, cater for maternal health care needs of more than half of Kenya's population.[223] The

213. *See id.* art. 43; *Mandate and Functions of the Commission*, NAT'L GENDER & EQUAL COMM'N (2020), https://www.ngeckenya.org/about/15/mandate [https://perma.cc/9V2W-38Q3].

214. *See* CONSTITUTION art. 4(2) (2010) (Kenya).

215. *Id.* art. 6.

216. *Id.* art. 10(2)(a).

217. *See id.* Fourth Schedule.

218. *See id.* Fourth Schedule, Part 2 (2)(a)–(c).

219. *See id.*

220. *See* Valerie Benka, Salvador Maturana & Devi Glick, Child and Maternal Health in Kenya: A Review and Analysis of Access and Outcomes 5–6 (Winter 2012) (Applied Policy Seminar, University of Michigan).

221. *Id.* at 4–6.

222. *See* Fotso & Mukiira, *supra* note 101, at 507.

223. *See* NAT'L COORDINATING AGENCY FOR POPULATION & DEV., MINISTRY OF HEALTH, CENT. BUREAU OF STAT. & ORC MACRO, OVERVIEW OF THE HEALTH SYSTEM IN KENYA, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2004, at 15–16 (2005).

private sector facilities are a major supplement to public health facilities.[224] There are equivalent private health providers at most of the levels offered by government providers.[225] The adequately equipped private health care facilities usually offer services after out-of-pocket expenditure.[226] Patients must pay cash before treatment can commence.[227] It is not surprising that poor sick women are denied vital health services in private hospitals because they could not make deposits or show evidence of a capacity to pay.[228] The private hospitals may collaborate with Kenya's Reproductive Health and Child Health Divisions of the Ministry of Health in offering maternity services.[229]

D. The Role of Development Partners

Kenya has enjoyed continuous funding for the health sector from various development partners, but the donor assistance for essential maternal health activities has varied over the years.[230] Kenya receives assistance from many European donors.[231] There has been a continuous increase in donor assistance from developed countries, the United Nations system, philanthropic foundations, non-governmental organizations (NGOs), and the development bank grants.[232] However, most of the funding from the donors is directed towards the HIV/AIDS projects.[233] In order to have improved maternal health services delivered in Kenya, the government and its development partners need to strongly commit to increase expenditure on maternal health programs,[234] and increase efficiency in resource utilization.[235] The national and county governments must recognize the need to be accountable to the donors, civil society, and

224. *See* Benka et al., *supra* note 220, at 8–9.
225. *Id.*
226. *See* Estelle M Sidze, Jalandhar Pradhan, Erik Beekink, Thomas M. Maina & Beatrice W. Maina, *Reproductive Health Financing In Kenya: An Analysis Of National Commitments, Donor Assistance, And The Resources Tracking Process, Reproductive Health Matters*, 21 REPROD. HEALTH MATTERS 139, 142–43 (2013).
227. *Id.* at 146.
228. *Id.*
229. *See* Benka et al., *supra* note 220, at 8–9.
230. *See* Sidze et al., *supra* note 226, at 145.
231. *Id.*
232. *Id.* at 144–45.
233. *Id.* at 145.
234. *See* Timothy Abuya, Rebecca Njuki, Charlotte E. Warren, Jerry Okal, Francis Obare, Lucy Kanya, Ian Askew & Ben Bellows, *A Policy Analysis of the Implementation of a Reproductive Health Vouchers Program in Kenya*, 12 BMC PUB. HEALTH, July 2012, at 13.
235. *See* Sidze et al., *supra* note 226, at 143–44.

the United Nations to ensure transparency and accountability for the allocated funds.[236] Kenya, like many African governments, often lacks the technical instruments needed to plan for adequate budgets.[237] This could be compounded by the unavailability of data for maternal health status in the informal settlements, which is necessary for prioritizing resource allocation.[238]

E. Maternal Health Financing in Kenya

1. Current Trends on Maternal Health Care Financing in Kenya

Adequate financial resources are significant for sustaining health care services.[239] Taxation, user fees, donor funds, and health insurance are important techniques of health care financing.[240] These fundraising methods have progressed into essential mechanisms for funding health services in the country.[241] The government funds about thirty one percent of the total public health care expenditure.[242] The proportion of expenditure on maternal health has remained constant at one percent.[243] Allocation of financial resources to the counties is based on a resource allocation plan developed by the Commission for Revenue Allocation.[244] The county governments collect taxes at a devolved level and may use some of these funds, although limited in capacity.[245] Furthermore, in consultation with the national government, the county governments may negotiate for credit facilities, including from foreign lenders.[246] In the private sector, maternal health services are financed primarily through the proceeds collected from user fees and insurance premiums charged to consumers.[247]

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236. *See id.* at 146–47.
237. *See id.* at 147–48.
238. *Id.*
239. *See* NAT'L COORDINATING AGENCY FOR POPULATION & DEV. ET AL., *supra* note 223, at 24.
240. *Id.* at 23–24.
241. *Id.*
242. *See* MINISTRY OF HEALTH, KENYA NATIONAL HEALTH ACCOUNTS 2012/2013 12–13 (2015).
243. *Id.* at 42.
244. *See* COMM'N ON REVENUE ALLOCATION, RECOMMENDATION ON THE SHARING OF REVENUE RAISED NATIONALLY BETWEEN THE NATIONAL AND COUNTY GOVERNMENTS FOR THE FINANCIAL YEAR 2016/2017 34–35 (2015).
245. *See id.*
246. *See id.*
247. *See* NAT'L COORDINATING AGENCY FOR POPULATION & DEV. ET AL., *supra* note 223, at 24–25.

2. The Kenya National Hospital Insurance Fund

a. Overview of the National Hospital Insurance Fund

The National Hospital Insurance Fund (NHIF) is a public corporation managed under the provisions of the National Hospital Insurance Fund Act of 1998.[248] The fund is managed by a board which reports to the Minister of Health.[249] Management of NHIF is done by a team headed by a Chief Executive Officer (CEO).[250] Membership of the NHIF is compulsory for all formal sector workers, and voluntary for the informal sector.[251] The majority of women living in the informal settlements work in the informal sector and cannot afford to pay monthly premiums to the insurance fund.[252] The NHIF covers outpatient and inpatient service benefits which are pegged according to the hospital category.[253]

> The NHIF also manages the Civil Servants and Disciplined Forces Medical Benefits Scheme, which provides comprehensive cover-[age] for outpatient and inpatient services, group life coverage, and funeral expenses . . . . Members of this scheme can access services at accredited public and private health service providers, depending on their preferences. Members can change their choice of health provider every six months.[254]

The NHIF is mandated to provide finances for essential medical equipment to facilities in underserved areas.[255] The NHIF was mandated to provide affordable and sustainable health insurance through efficient utilization of resources to the satisfaction of contributors.[256]

3. Challenges of Implementing the NHIF in Relation to Women Living in Informal Settlements

The government of Kenya provides health care coverage through the NHIF, which covers mainly inpatient benefits to its members

248. *See* National Hospital Insurance Fund Act, No. 9 (1998) LAWS OF KENYA.
249. *Id.* § 4.
250. *Id.* § 10(1).
251. *See id.* §§ 15, 20.
252. *See* Alder, *supra* note 38, at 100.
253. *See* National Hospital Insurance Fund Act § 30.
254. Kenneth Munge, Stephen Mulupi & Jane Chuma, *A Critical Analysis of the Purchasing Arrangements in Kenya: The Case of the National Hospital Insurance Fund, Private and Community-based Health Insurance* (RESYST, Working Paper No. 7, 2015).
255. *See id.* at 14–15.
256. REPUBLIC OF KENYA, HEALTH SECTOR WORKING GROUP REPORT: MEDIUM TERM EXPENDITURE FRAMEWORK (MTEF) FOR THE PERIOD 2015–16 TO 2017–18, at 6–7 (2014).

and their beneficiaries.[257] The NHIF coverage in Kenya is limited in terms of the numbers covered and the resources controlled by the insurance sector.[258] Although there are efforts to offer citizens working in both the formal and informal sectors insurance coverage, there is no legal obligation to make premium payments to the scheme by people working in the informal sector.[259] On the other hand, the affluent populations will choose not to contribute to funding for services needed by the poor and the sick.[260] Voluntary health insurance schemes are not able to cover services for the women living in the informal settlements who are unable to pay insurance premiums.[261] This is a major concern in Kenya's urban informal settlements with high poverty levels.[262] Therefore, it is difficult to achieve universal health care through insurance schemes when enrollment is voluntary.[263] It is important for the government to study other helpful and reasonable means of generating revenue from the informal sector that can fund maternal health services.[264]

The Constitution of Kenya 2010 provides for the right to health.[265] The enjoyment of this right by the poor women living in the informal settlements depends on the implementation of the free maternity care.[266] Despite the legislation of free maternity care in 2017, many women are required to pay indirect costs to access maternal health services in the public health facilities.[267]

4. The Linda Mama Initiative

In 2016, the government of Kenya launched the expanded free maternal care program christened "Linda Mama, Boresha Jamii", translated to mean "Protect mothers for a better society."[268] The

257. *See* Karanja Jane Wanjiru, Challenges in Provision of Universal Health Care by The National Hospital Insurance Fund 5–6 (Nov. 2014) (M.B.A. Thesis, Nairobi University) (on file with the author).

258. *See* Sidze et al., *supra* note 226, at 144.

259. *See* Wanjiru, *supra* note 257, at 14.

260. *Id.* at 15.

261. *Id.* at 8.

262. *Id.*

263. *Id.* at 15.

264. *Id.* at 16.

265. CONSTITUTION art. 43(1)(a) (2010) (Kenya).

266. *See* Evaline Lang'at & Lillian Mwanri, *Healthcare Service Providers' and Facility Administrators' Perspectives of The Free Maternal Healthcare Services Policy in Malindi District, Kenya: A Qualitative Study*, 12 REPROD. HEALTH 1, 5 (2015).

267. *See* Nation Team, *Linda Mama: The Free Service Mothers Are Paying For*, NATION (Jan. 13, 2020), https://nation.africa/kenya/healthy-nation/linda-mama-the-free-service-mothers-are-paying-for-240498 [https://perma.cc/8NSB-4QMX].

268. Rhoda Odhiambo, *State Expands Free Maternity Services*, THE STAR (Oct. 19,

Linda Mama initiative was aimed at improving access and quality of maternal, newborn and child health care services in the country.[269] The benefit package includes both outpatient and inpatient services for the mother and newborn for one year.[270] It will further include antenatal care, delivery, postnatal care and emergency referrals for pregnancy-related conditions as well as complications.[271] However, for women to benefit from this program, they need to register with the National Hospital Insurance Fund and remit monthly premiums despite their unstable and meager financial resources.[272] The National Hospital Insurance Scheme does not consider the economic vulnerability of many women living in informal settlements, who cannot afford to pay the required monthly premiums.[273] Therefore, many women in the informal settlements miss out on the benefit of the Linda Mama, Boresha Jamii initiative.[274]

IV. EXISTING LEGAL FRAMEWORKS ON MATERNAL HEALTH CARE

A. Domestic Frameworks and Policies on Maternal Health Rights

1. The Constitution of Kenya 2010

Chapter 4 of the Constitution of Kenya 2010 contains the Bill of Rights, which encompasses the basic, social-political and economic rights.[275] The Bill of Rights promotes social justice and preserves human dignity to the greatest extent possible.[276]

Every Kenyan woman has the inalienable right to the highest attainable standard of maternal and reproductive health care.[277] The State is mandated by the Bill of Rights to ensure equitable allocation of resources to safeguard the health rights of vulnerable

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2016), https://www.the-star.co.ke/news/2016-10-19-state-expands-free-maternity-services [https://perma.cc/Z86X-6B32].

269. *HP+ Costing Work Helping to Expand Kenya's Free Maternal Health Program, Reaching 700,000 Women Each Year*, HEALTH POL'Y PLUS (May 2, 2018), http://www.healthpolicyplus.com/KenyaLindaMama.cfm [https://perma.cc/UN43-NSFB].

270. *See* Nation Team, *supra* note 267.

271. *See HP+ Costing Work Helping to Expand Kenya's Free Maternal Health Program, Reaching 700,000 Women Each Year*, *supra* note 269.

272. F. MURIRA, THINKWELL, IMPROVING FACILITY IMPLEMENTATION OF LINDA MAMA IN MAKUENI COUNTY 1 (2019), https://thinkwell.global/wp-content/uploads/2020/02/Makueni-Linda-Mama-Performance-brief-2020_02_131.pdf [https://perma.cc/TJ4Z-H82C].

273. *See id.* at 2.

274. *See* Nation Team, *supra* note 267.

275. CONSTITUTION chap. 4 (2010) (Kenya).

276. *Id.* art. 19(2).

277. *Id.* art. 43(1)(a).

groups, including women living in the informal settlements.[278] The State is duty-bound to protect the poor women living in the informal settlements through the enactment of laws and formulation of policies that will address their needs and safeguard full enjoyment of their maternal health rights.[279] The equality and non-discrimination provisions in the Bill of Rights ensure that every Kenyan living in the informal settlements has the right to enjoy equal protection and equal benefit of the law.[280] Kenya has an obligation to protect women living in the urban informal settlements from discriminatory practices that may hinder realization of their maternal health rights.[281] The Bill of Rights safeguards the rights and freedoms of marginalized groups, including women living in the urban informal settlements, through progressive policies.[282]

The Constitution recognizes that Kenyan citizens can exercise their sovereign power either directly or through their democratically elected representatives.[283] The Constitution also bestows upon Kenyan citizens the civilian oversight of implementation and realization of their maternal health rights.[284] Individuals can act in their own interest, or through the civil society and human rights organizations, to institute legal proceedings against the State when their rights have been threatened, denied, violated or infringed.[285] The courts hearing the litigation on the right to health often face challenges in determining the extent to which the right to health is enforceable[286] and what resources the government must devote towards the right to health.[287] Successful litigation in other jurisdictions has often involved access to essential health services.[288] Domestic litigation demonstrates the justiciability of the maternal health rights, which have often been linked to the right to life.[289] The focus on marginalized populations is consistent with the human rights principle of non-discrimination.[290]

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278. *Id.* art. 20.
279. *Id.* art. 21.
280. *Id.* art. 27.
281. CONSTITUTION art. 20(2) (2010) (Kenya).
282. *Id.* art. 56(e).
283. *Id.* art. 1.
284. *Id.*
285. *Id.* art. 22(1)–(2).
286. *See* LAWRENCE GOSTIN, GLOBAL HEALTH LAW 267, 268 (2014).
287. CONSTITUTION art. 20(5)(c) (2010) (Kenya).
288. *See* Minister of Health v. Treatment Action Campaign 2002 (5) SA 5 (CC) at 19 (S. Afr.), https://www.escr-net.org/caselaw/2006/minister-health-v-treatment-action-campaign-tac-2002-5-sa-721-cc [https://perma.cc/2AQY-6TKU].
289. CONSTITUTION art. 26(1) (2010) (Kenya).
290. *See* GOSTIN, *supra* note 286, at 262.

2. The Health Act 2017

a. Establishment of the Free Maternity Care

The Health Act, 2017, established the National Health System that recognizes every Kenyan citizen's right to the highest attainable standard of health including maternal health care.[291] The Act recognizes the vulnerable group of women living in the informal settlements and ensures the provision of free and compulsory maternity care for them.[292] The Act abolished user fees for pregnant women and mandated the national government to fund the free maternity care.[293] However, the Act does not provide funding sources for the free maternity care program.[294] The abolition of user fees was intended to lessen the financial burden of pregnancy and childbirth while increasing facility-based deliveries.[295] Although the Ministry of Health was mandated to develop health policies and administrative procedures,[296] the Act did not identify the funding sources for the implementation of the free maternity care.[297] The Act provides every Kenyan citizen the right to file a complaint regarding the health services received or denied and establishes a complaint mechanism within the National Health System.[298]

b. Implementation of the Free Maternity Care

The introduction of the free maternity care in 2013 resulted in overall increased public health facility deliveries in Kenya.[299] However, the maternal mortality index did not decrease significantly.[300] The inadequate health care facilities, medical supplies and financial resources have hindered the successful implementation of this program.[301] The public health facilities available in the informal settlements are largely understaffed and ill-equipped to handle emerging

291. *See* The Health Act, No. 21 (2017), KENYA GAZETTE SUPPLEMENT No. 101 § 5(1).
292. *Id.* § 5(3)(b).
293. *Id.* § 5(4).
294. *Id.* § 5(3).
295. *See* Laurel E. Hatt, Marty Makinen, Supriya Madhavan & Claudia M. Conlon, *Effects of User Fee Exemptions on The Provision and Use Of Maternal Health Services: A Review Of Literature*, 31 J. HEALTH, POPULATION & NUTRITION 67, 68 (2013).
296. *See* The Health Act, No. 21 (2017), KENYA GAZETTE SUPPLEMENT No. 101 § 15(1)(a).
297. *See id.* § 5(3).
298. *Id.* § 14(1).
299. *See* C. M. Gitobu, P. B. Gichangi & W. O. Mwanda, *Satisfaction with Delivery of Services Offered Under the Free Maternal Health Care Policy in Kenyan Public Health Facilities*, J. ENV'T & PUB. HEALTH, 2018, 1, 1.
300. *Id.*
301. *Id.* at 2.

health issues affecting the vulnerable populations.[302] The hurried implementation of the free maternity services highlighted the inadequacies of the existing public health facilities to cope with the increased demand for maternity services in the informal settlements.[303] The free maternity program compounded the shortages of skilled health workers, medical facilities and supplies in the informal settlements.[304]

Financial and human resources are significant for implementing free maternal health care in public hospitals.[305] There is a strong connection between resource allocation and implementation of free maternity services.[306] Insufficient resources impede implementation of free maternity care.[307] Inadequate funding of the free maternity program causes implementation failure of the policy leading to women paying for free services.[308] Although the maternal health care services are free, lack of supplies and facilities make it costly as women living in informal settlements seek other linked services elsewhere.[309] Health infrastructure is critical to ensure successful implementation of free maternity care.[310] There is a relationship between hospital infrastructure and the implementation of free maternity services in the public hospitals.[311]

The Kenyan public health facilities have long suffered from insufficient health infrastructure, equipment and staffing.[312] The problem of inadequate staffing has further been enhanced by the introduction of free maternity services in public health facilities.[313] The available public health care staff are overwhelmed by the increased facility deliveries occasioned by the introduction of free maternity services in all public hospitals in Kenya.[314] The maternity wards in public hospitals are often overcrowded.[315] Many women

302. *See* Mutua et al., *supra* note 104, at 2.
303. *Id.* at 8.
304. *Id.*
305. *See* Abuya et al., *supra* note 234, at 13.
306. *See id.*
307. *See* Lang'at & Mwanri, *supra* note 266, at 5.
308. *Id.*
309. See Mutua et al., *supra* note 104, at 9.
310. *See* WHO, WORLD HEALTH STATISTICS 2010, at 113, http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf?ua=1 [https://perma.cc/G8JJ-X47A].
311. *See* Lang'at & Mwanri, *supra* note 266, at 5.
312. *Id.*
313. *Id.*
314. *See* Dennis O. Orare, Wangombe Ann, Muchiri Francis, Chimbevo Mwagambo & Ooga Westley, *The Roles of Infrastructure and Resources on Implementation of Free Maternal Healthcare Services in Machakos Level 5 Hospital, Machakos County, Kenya*, 5 SCIENCE J. PUB. HEALTH 49, 55 (2017).
315. *See* Lang'at & Mwanri, *supra* note 266, at 4.

who deliver their babies in the overstretched public health facilities often face potential health hazards due to overcrowding and the diminished quality of care.[316]

The successful implementation of the free maternity program may be specifically beneficial to the women living in the urban informal settlements.[317] This vulnerable population has been overlooked by the previous and even current administrations.[318] The socioeconomical marginalization has resulted in poorer health outcomes compared to the other urban residents.[319] In order for the program to be successful, the national and county governments may need to address the various constraints to its successful implementation.[320] The county governments lack transparency and accountability in resource allocations, as well as the capacity to cope with the increased demand for maternity services.[321]

3. The Kenya Health Policy 2014–2030

The Kenya Health Policy 2014–2030 signals Kenya's commitment to improve the overall health status of its citizens in line with the Constitution of Kenya 2010, Vision 2030, and other international instruments.[322] The policy considers the functional responsibilities between the two levels of government,[323] and incorporates a multisectoral approach in the realization of the right to health and economic development in Kenya.[324] The policy emphasizes on efficiency, accountability and transparency in the health care service delivery.[325] The policy has been formulated to be operational within the devolved health care system,[326] in order to attain the highest possible standard of health in a responsive manner.[327] The policy champions the rights and fundamental freedoms of marginalized groups of persons,

316. *See* BOURBONNAIS, *supra* note 166, at 6–7.
317. *See* Gitobu et al., *supra* note 299, at 2.
318. *See* Mutua et al., *supra* note 104, at 11.
319. *See id.* at 9.
320. *See id.* at 1.
321. *See id.* at 9.
322. *See* James W. Macharia, *Foreword* to MINISTRY OF HEALTH, KENYA HEALTH POLICY 2014–2030 TOWARDS ATTAINING THE HIGHEST STANDARD OF HEALTH (2014), http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030pdf [https://perma.cc/K2TK-STZJ].
323. MINISTRY OF HEALTH, KENYA HEALTH POLICY 2014–2030 TOWARDS ATTAINING THE HIGHEST STANDARD OF HEALTH 3 (2014).
324. *Id.*
325. *Id.*
326. *Id.* at 4.
327. *Id.*

including the women living in the informal settlements.[328] Although the policy enshrines the human rights-based approach in maternal health care delivery, it has not incorporated the free maternity services that seek to realize the maternal health rights of marginalized women living in the informal settlements.[329]

B. Regional Frameworks and Instruments on Maternal Health Rights

1. The African Charter on Human and Peoples' Rights (Banjul Charter)

The charter provides for individuals to enjoy the highest attainable state of physical and mental health.[330] State parties to the Banjul Charter, including Kenya, are mandated to take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick.[331] The Charter established the African Commission on Human and Peoples' Rights within the African Union (previously the Organization of African Union) to promote and safeguard human and peoples' rights in Africa.[332] The African Commission on Human and Peoples' Rights delivered a significant ruling on the right to health.[333] The Commission also held Gambia responsible for failing to ensure the right to health for persons with disabilities, without discrimination.[334] The commission monitors compliance of state parties to their obligations under the instrument.[335]

2. The Abuja Declaration on HIV & AIDs, Tuberculosis and Other Diseases

The Abuja Declaration adopted by African heads of state committed them to increase budgetary allocation for health in their countries to at least fifteen percent of their annual budget.[336] Kenya

328. *See* CONSTITUTION art. 19 (2010) (Kenya).

329. *See* MINISTRY OF HEALTH, *supra* note 323.

330. African (Banjul) Charter on Human and Peoples' Rights art. 16(1), June 27, 1981, O.A.U. Doc CAB/LEG/67/3 rev. 5 [hereinafter Banjul Charter].

331. *Id.* art. 16(2).

332. *Id.* art. 30.

333. *See* Sisay A. Yeshanew, *Approaches to The Justiciability of Economic, Social and Cultural Rights in The Jurisprudence of The African Commission on Human and Peoples' Rights: Progress and Perspectives*, 11 AFR. HUMAN RTS. L.J. 317, 330 (2011).

334. *See* GOSTIN, *supra* note 286, at 262.

335. *See* Banjul Charter, *supra* note 330, at art. 45(2).

336. *See* Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases ¶26, Apr. 24–27, 2001, O.A.U./S.P.S./ABUJA 3 [hereinafter Abuja Declaration],

signed the Abuja Declaration, thereby pledging with the African Union countries to allocate at least fifteen percent of its annual budget to improve the health sector.[337] Kenya's commitment to the Declaration has been the benchmark for advocating for increased government spending on the health care sector.[338] Twenty-six countries have increased their government spending to improve the health sector since 2001.[339] "However, only Tanzania has achieved the Abuja Declaration target of 'at least 15%.'"[340] Kenya has also failed to meet the Abuja Declaration target.[341] The maternal health budgetary allocation has been decreasing over the years.[342] In the past year Kenya allocated 7.5–7.7% of the government's total budget towards the health sector.[343] The special grant for Free Maternity Program of Ksh 3.4 billion has been reduced by Ksh 900 million, compared to 2016/17.[344] Abolition of the user fees in the public health facilities has deprived them of essential sources of health care financing.[345] Funding for the maternal health care is inadequate to cater for the needs of women living in informal settlements.[346] This is not enough to meet the demand for services, which entail availability of facilities and supplies at the public hospitals.[347] These financial challenges hinder the successful implementation of the free maternal health program in the informal settlements.[348]

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

This is the only regional instrument that expressly incorporates the right to maternal and reproductive health for all women.[349] The Maputo Protocol, which Kenya ratified, emphasizes the need for states parties to respect and promote the right to health of women,

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https://au.int/sites/default/files/pages/32904-file-2001_abuja_declaration.pdf [https://perma.cc/YZQ9-9UKZ].

337. *Id.*

338. *See* MINISTRY OF HEALTH, NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS FY 2018/19, at 6 (2018), http://www.healthpolicyplus.com/ns/pubs/11306-11563_NationalandCountyBudgetAnalysis.pdf [https://perma.cc/2623-2ZMF].

339. *See* WHO, *supra* note 31, at 3.

340. *Id.*

341. *See* NAT'L COORDINATING AGENCY FOR POPULATION & DEV. ET AL., *supra* note 223, at 24.

342. *See* MINISTRY OF HEALTH, *supra* note 338, at 6.

343. *Id.*

344. *Id.*

345. *See* KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 143.

346. See *id.* at 138.

347. *See* BOURBONNAIS, *supra* note 166, at 3.

348. *See* KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 31.

349. *See* GOSTIN, *supra* note 286, at 260–61.

including sexual and reproductive health.[350] The Protocol requires the states parties to respect and promote the reproductive and health rights of women by establishing and strengthening the existing maternal health and nutritional services for women.[351] The Protocol also requires the state parties to ensure availability and accessibility of maternal and reproductive health services, including medical abortions.[352] Kenya entered her reservations on Article 14(2)(c) of The Protocol relating to medical abortions.[353] However, 2010 enactment of the Constitution of Kenya resulted in integration of the ratified treaties into the domestic laws.[354] This presents a legal dilemma regarding the provision of safe abortion services in Kenya and requires legal clarification.[355]

C. International Frameworks and Instruments on Maternal Health Rights

1. Non-binding Instruments on the Right to Health

a. The Constitution of the World Health Organization

The right to health was first articulated in the World Health Organization's Constitution (1946), which envisioned, "the enjoyment of the highest attainable standard of health [as a] fundamental right of every human being."[356] The preamble of the Constitution defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[357] The Constitution also recognizes the right to health as both central to, and dependent upon, the realization of other human rights.[358] Member

350. *See* Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, July 11, 2003, African Union Assembly, Decision on the Draft Protocol to the African Charter on Human and Peoples' Rights Relating to Women, Assembly /AU/Dec. 19 (III), art. 14 (July 11,2003) [hereinafter Maputo Protocol], https://au.int/en /treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa [https://perma.cc/M78U-M8GF].

351. *Id.* art. 14(1), (2)(b).

352. *See* KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 66.

353. *See* Maputo Protocol, *supra* note 350, at art. 14(2)(c); KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 66.

354. CONSTITUTION art. 2(6) (2010) (Kenya).

355. *See* FED'N OF WOMEN LAWYERS KENYA, THE STATUS OF SAFE ABORTION IN KENYA: A BASELINE REPORT 7–8 (2019).

356. *See* WHO CONSTITUTION (45 ed. Supp. Oct. 2006), http://www.who.int/governance /eb/who_constitution_en.pdf [https://perma.cc/LSG9-CMAN].

357. *Id.*

358. *See Human Rights and Health*, WHO (Dec. 29, 2017), http://www.who.int/media centre/factsheets/fs323/en [https://perma.cc/GED4-M7B5].

states are obligated to ensure suitable conditions for the enjoyment of the highest standard of health for all people without discrimination.[359] The women living in the informal settlements do not enjoy the highest attainable standard of health care.[360] They face significant barriers to accessing much needed health care services.[361] The World Health Organization is devoted to improving health care policies and programs that will improve the health status of women around the world.[362] The World Health Organization advocates and strengthens the capacity of member states to propagate the right to health.[363]

b. The Beijing Declaration and Platform for Action

In 1995, the Beijing Declaration and Platform for Action was adopted by 187 United Nations member-states to advance women's human rights goals of equality, development, and peace.[364] The Declaration reaffirmed the commitment of UN member states to, "the equal rights and inherent human dignity of women and men" as "enshrined in . . . other international human rights instruments."[365] Maternal and reproductive health rights are, "human rights that are already recognized in national laws, international human rights documents, and other . . . documents."[366] Women's human rights encompass their right to have control over and decide issues, "related to their sexuality, including sexual and reproductive health."[367]

The Declaration recognized the government's role in promoting and safeguarding women's right to health without discrimination.[368] Women in the informal settlement are socioeconomically marginalized and may not fully enjoy their health rights. This may be perpetuated by national health policies and programs that do not consider the socioeconomic disparities among women when promoting maternal and reproductive health rights.[369] The Declaration lacks specific procedures for holding governments legally accountable to

359. *See* WHO CONSTITUTION, *supra* note 356.
360. *See* BOURBONNAIS, *supra* note 166, at 7–8.
361. *See Human Rights and Health*, *supra* note 358.
362. *See* WHO CONSTITUTION, *supra* note 356, art. 2(l).
363. *See Human Rights and Health*, *supra* note 358.
364. *See* Report on the Fourth World Conference on Women, *Beijing Declaration and Platform of Action*, ¶¶ 92, 105, U.N. Doc. A/CONF.177/20 (Sept. 1995) [hereinafter Beijing Declaration].
365. *Id.* ¶ 8.
366. *See id.* ¶ 95.
367. *Id.* ¶ 96.
368. *Id.* ¶ 95.
369. *See id.* ¶ 91.

women's human rights, including the right to maternal health.[370] Such mechanisms generally exist in national laws, constitutions, and in regional and international human rights treaties.[371]

Monitoring state compliance requires a clear understanding of each human right and the connected obligations of member states as duty bearers.[372] Many states commit themselves to promote and protect the human rights of women through national constitutions and by membership in regional and international human rights conventions.[373]

2. Binding Instruments on the Right to Health

a. Universal Declaration of Human Rights

The Universal Declaration of Human Rights sets a common standard for achieving the right to adequate health.[374] Article Twenty-Five states that, "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services[.]"[375] The Declaration recognizes the need for states to provide crucial social services, including the medical facilities and supplies that are essential for the realization of the right to health.[376] Provision of these important commodities will strengthen the capacity of the public health sector in alleviating the maternal health challenges for women living in the informal settlements.[377] Universal health coverage is the practical expression of the right to health as enshrined in the Declaration.[378] Although this Declaration lacks the full force of the law, it is considered the customary international law and its key provisions are widely regarded as binding to member states.[379]

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370. *See* Beijing Declaration, *supra* note 364, ¶ 30.

371. *See* BOURBONNAIS, *supra* note 166, at 4–5.

372. *See* Rebecca J. Cook & Mahmoud F. Fathalla, Comment, *Advancing Reproductive Rights Beyond Cairo And Beijing*, 22 ADVANCING REPROD. RTS. 115, 117 (1996).

373. *Id.* at 115.

374. *See* G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948).

375. *Id.* art. 25(1).

376. *See id.*

377. *See* KENYA NAT'L COMM'N ON HUM. RTS., *supra* note 143, at 36.

378. *See* G.A. Res. 217 (III), *supra* note 374, at art. 25; *see also* Gorik Ooms, Laila A. Latif, Attiya Waris, Claire E. Brolan, Rachel Hammonds, Eric A. Friedman, Moses Mulumba & Lisa Forman, *Is Universal Health Coverage the Practical Expression of the Right to Health Care?*, 14 BMC INT'L HEALTH & HUM. RTS., Feb. 24, 2014, 1–2.

379. *See* GOSTIN, *supra* note 286, at 250.

b. International Covenant on Economic, Social and Cultural Rights

The most comprehensive articulation of the right to health is set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR).[380] The ICESCR stipulates that states parties to the covenant should recognize the right for every individual to, "enjoy[] the highest attainable standard of physical and mental health."[381] The Covenant recognizes that these rights cannot be achieved immediately.[382] The legal obligations of states parties are set out in Article Two of the ICESCR.[383] The states parties are required to take specific steps stipulated in the Covenant to ensure the full realization of the right to health for all its citizens.[384] The states parties must develop health care infrastructure and implement progressive legal reforms to attain health rights for all women, including those living in the informal settlements.[385] Kenya ratified the Covenant and is required to commit its resources towards progressively achieving the full realization of maternal health rights for all women, including those living in the informal settlements.[386] Kenya is also required to adopt legislative measures, when needed, to ensure access to health care for all its citizens.[387] By ratifying the Covenant, Kenya is expected to take necessary measures that would ensure non-discrimination in health care service delivery for women living in the informal settlements.[388] The Covenant includes an optional protocol to monitor violations and enforce human rights.[389] However, Kenya made reservations to this optional protocol regarding the complaint mechanisms.[390]

The implementation of the International Covenant on Economic, Social and Cultural Rights by states parties is monitored by the eighteen independent experts in the Committee on Economic, Social and Cultural Rights (CESCR).[391] The obligations of states parties

380. *See* G.A. Res. 2200 (XXI) A, International Covenant on Economic, Social and Cultural Rights, art. 12 (Dec. 16, 1966) [hereinafter ICESCR].
381. *Id.*
382. See *id.* art. 2.
383. *Id.*
384. *See id.* art. 12.
385. *See id.*
386. *See* ICESCR, *supra* note 380, at art. 12.
387. *See id.*
388. *See id.* art. 2.
389. *See* Human Rights Council, Res. 8/2, U.N. Doc. A/RES/63/117 (Dec. 10, 2008).
390. *See* ICESCR, *supra* note 380, at art. 10(2).
391. *Committee on Economic, Social And Cultural Rights*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R, http://www.ohchr.org/en/hrbodies/cescr/pages/cescrindex.aspx [https://perma.cc/TT8H-JBAJ].

towards implementation of the right to health are spelled out in the General Comment Number Fourteen of the CESCR.[392] This includes the core obligation of ensuring the right to access maternal health care, on a non-discriminatory basis, especially for vulnerable or marginalized group.[393] The states parties have a duty to adopt legislation or to take other measures that eliminate discrimination and ensure equal access to health care and health-related services provided by third parties.[394] States parties are required to legislate the right to health and, "adopt national health policies with a detailed plan for realizing the right to health."[395] This entails taking necessary steps to accelerate and promote conditions in which the right can be realized, including improvement of the health infrastructure.[396] The states parties are also obligated to take positive measures that enable and assist vulnerable individuals and communities to enjoy their right to the highest attainable health care.[397] Although the general comment is not binding on states parties, General Comment Number Fourteen illustrates how countries can modify the determinants of health to attain the right to the highest standards of health for its citizens.[398]

There are Special Rapporteurs consisting of independent experts that are, "appointed by the Human Rights Council to examine and report back on a country situation or a specific human rights theme."[399] "The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" can be implemented through various approaches.[400] They can compile annual reports on the rights status of states parties, conduct country visits to obtain first-hand information on the implementation of the right to health, or hear individual complaints regarding a country's non-compliance to the ICESCR.[401] The Special Rapporteurs can also recommend corrective measures for a country's violation of the right to health.[402]

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392. *See* Economic and Social Council, General Comment No. 14, ¶¶ 43–44, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

393. *See id.* ¶ 43(f).

394. *Id.* ¶ 35.

395. *Id.* ¶ 36.

396. *Id.* ¶¶ 34–36.

397. *See id.* ¶¶ 12–13.

398. *See* Economic and Social Council, *supra* note 392, ¶¶ 59–64.

399. *See Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN, http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx [https://perma.cc/L7ZA-7FX8].

400. *Id.*

401. *Id.*

402. *See* GOSTIN, *supra* note 286, at 260.

Kenya has incorporated the right to health for all citizens in its Bill of Rights[403] and the Health Act 2017.[404] Kenya is obligated to "respect, protect, and fulfil [sic]" the right to health.[405] The free maternity care introduced in 2013 was expected to ensure progressive realization of maternal health rights for all women in Kenya.[406] However, its hurried implementation without a specific policy and funding source threatens to hinder realization of maternal health rights for women living in the informal settlements.[407] Kenya adopted a comprehensive health policy,[408] but did not incorporate clear guidelines on the implementation of the free maternity program.[409] The realization of the right to maternal health care for women living in the informal settlements requires the formulation of a specific policy for free maternity care.[410] Kenya has an obligation to implement the provisions of the Health Act requiring free maternity services.[411]

c. Convention on Elimination of Discrimination Against Women

Kenya is party to the Convention on Elimination of Discrimination Against Women.[412] The Constitution of Kenya provides that treaties and conventions ratified by Kenya form part of the law of the land.[413] The convention mandates states to take all applicable measures to eliminate discrimination against women in the field of health care to ensure access to health care services, including those related to family planning.[414] Any restriction denying women human rights is deemed as discrimination.[415]

Although Kenya is party to these international instruments it has failed to ensure access to maternal health care for women living in informal settlements.[416] This violates women's right to health

403. CONSTITUTION art. 43(1)(a) (2010) (Kenya).
404. *See* Health Act, No. 21 (2017), KENYA GAZETTE SUPPLEMENT No. 101 § 5.
405. *See* Economic and Social Council, *supra* note 392, ¶ 33.
406. *See* BOURBONNAIS, *supra* note 166, at 3.
407. *Id.* at 3–4.
408. *See* MINISTRY OF HEALTH, *supra* note 323.
409. *See* Tama et al., *supra* note 20, at 609–10.
410. *See* BOURBONNAIS, *supra* note 166, at 3–4.
411. *See id.*
412. *See* G.A. Res. 34/180, Convention on Elimination of all Forms of Discrimination Against Women, U.N. Doc. A/34/36,1249 U.N.T.S. 13, *entered into force* (Mar. 3, 1981) [hereinafter CEDAW], http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf [https://perma.cc/VDZ8-7F5P].
413. CONSTITUTION art. 2(6) (2010) (Kenya).
414. CEDAW, *supra* note 412, at art. 12.
415. *Id.* art. 1.
416. *See* Jean Christophe Fotso, Alex Ezeh & Rose Oronje, *Provision and Use of Maternal Health Services among Urban Poor Women in Kenya: What Do We Know and*

care.[417] Women in these populations do not access to health care facilities.[418] The government's failure to provided health facilities and resources constitutes violation of the right to reproductive and maternal rights.[419] In Alyne da Silva Pimentel Teixeira v. Brazil, the CEDAW committee stated that lack of proper maternal health services by a state party to meet the needs of women constitutes a violation of the covenant.[420] The Committee emphasized that the State's obligations under CEDAW extend to monitoring the performance of private health care institutions, and that the State cannot outsource its obligation to ensure compliance with human rights obligations to private health services.[421] The Convention Elimination of Discrimination Against Women (CEDAW) requires states to ensure women have appropriate services in connection with pregnancy, including family planning and emergency obstetric care.[422] Improving maternal health reduces poverty and stimulates economic growth.[423]

General Recommendation No. 24 on women and health gives the definitive interpretation of CEDAW application on the right to health.[424] These recommendations require governments to eliminate discrimination against women in their access to health care services.[425] Mainly in the "areas of family planning, pregnancy and confinement and during the post-natal period."[426] It further offers specific direction to governments on their obligations to end discrimination against women under Article 12 of CEDAW.[427] The health status of vulnerable

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What Can We Do?, 85 J. URB. HEALTH 428, 429 (Apr. 4, 2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2329740/pdf/11524_2008_Article_9263.pdf [https://perma.cc/V3B4-8PPY].

417. *See* FAILURE TO DELIVER, *supra* note 4, at 79, 84.

418. *Id.* at 7.

419. *See Kenyan High Court upholds human and constitutional rights to maternal dignity and reproductive healthcare*, REPROHEALTHLAW BLOG (Mar. 15, 2019, 10:07 A.M.), https://reprohealthlaw.wordpress.com/2019/03/15/kenyan-high-court-upholds-human-and-constitutional-rights-to-maternal-dignity-and-reproductive-healthcare [https://perma.cc/W65W-Z9WC].

420. *See* Committee on the Elimination of All Forms of Discrimination Against Women, Comm. No. 17/2008, Statement Submitted by Maria de Lourdes da Silva Pimentel ¶7.6, UN Doc. CEDAW/C/49/D/17/2008 (2008).

421. *See id.* ¶7.5.

422. *See* U.N. Committee on the Elimination Against Women, CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), U.N. Doc. A/54/38/Rev. 1, chap. I ¶¶ 8, 27 (1999) [hereinafter General Recommendation No. 24], https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf [https://perma.cc/7NJ4-WWU5].

423. *See* U.N. Secretary-General, Global Strategy for Women's and Children's Health 6 (Sept. 2010).

424. General Recommendation No. 24, *supra* note 422, ¶ 1.

425. *Id.* ¶ 2.

426. *Id.*

427. *See id.* ¶¶ 9–27.

groups of women; refugees, minority, older and disabled should be prioritized by states.[428] The CEDAW committee requests that governments report on "health legislation, plans and policies for women with reliable data[.]"[429] States are encouraged to include information on measures they have taken to ensure appropriate services for pregnancy, confinement and the postnatal period.[430] Further, it should state the rates at which these measures have reduced maternal mortality and morbidity in the country.[431] Especially among vulnerable groups.[432] These recommendations encourage governments to take actions in eliminating discrimination against women.[433] Further, allocating adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget.[434] Thus placing a gender perspective,[435] at the heart of all policies and programs affecting women's health.[436]

V. IMPLEMENTATION OF MATERNAL HEALTH RIGHTS FOR WOMEN LIVING IN KENYA'S URBAN INFORMAL SETTLEMENTS

A. Formulation of a Specific Policy Guideline on the Free Maternity Care in Urban Informal Settlements

The Health Act 2017 legislated the free maternity care, abolished user fees for pregnant women,[437] and mandated the national government to fund the free maternity care especially among the vulnerable groups of women, including those living in the informal settlements.[438] The free maternity care was expected to ensure progressive realization of maternal health rights for all women in Kenya.[439] However, its hurried implementation without specific policy guidelines and funding sources threatens to hinder realization of maternal health rights for many women including those living in the informal settlements.[440]

Kenya adopted a comprehensive health policy,[441] but did not incorporate clear policy guidelines on the implementation of the free

428. *Id.* ¶ 6
429. *Id.* ¶ 9.
430. *See* General Recommendation No. 24, *supra* note 422, ¶ 26.
431. *Id.*
432. *Id.*
433. *See id.* ¶ 2.
434. *Id.* ¶ 17.
435. *Id.* ¶ 31(a).
436. General Recommendation No. 24, *supra* note 422, ¶ 31(a).
437. *See* The Health Act, No. 21 (2017), KENYA GAZETTE SUPPLEMENT No. 101 § (3)(b).
438. *Id.* § 4(c).
439. *See id.* § 4.
440. *See* Tama et al., *supra* note 20, at 609–10.
441. *See* MINISTRY OF HEALTH, *supra* note 323.

maternity care.[442] The realization of the right to maternal health care for women living in the informal settlements requires the formulation of specific policy guidelines for implementation of the free maternity care.[443] These guidelines should specify what services are provided free of charge and address the funding sources for implementation of the free maternity care.[444] The guidelines should particularly address the challenges of implementation of the maternity care in the urban informal settlements where health facilities are overstretched, understaffed, and largely run-down.[445]

B. Increasing Budgetary Allocation to Strengthen the Capacity of Public Health Facilities in Urban Informal Settlements

Kenya has an obligation to implement the provisions of the Health Act requiring free maternity services.[446] In the fiscal year 2017–2018, the special grant to fund the free maternity care in Kenya was to be transferred to the NHIF.[447] This would result in a significant reduction of funds devoted specifically towards the free maternity care.[448] Kenya is obligated to respect, protect and fulfill the right to health for women living in the informal settlements.[449] The Kenyan government is required to commit its resources towards funding the free maternity care for all women including those living in the informal settlements.[450] These resources would facilitate expansion of the capacity of existing public health facilities to cope with the additional demand for maternal health services in those

442. *See* Thidar Pyone, Helen Smith & Nynke van den Broek, *Implementation of the free maternity services policy and its implications for health system governance in Kenya*, 2 BMJ GLOB. HEALTH, Nov. 12, 2017, at 2, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5687545/pdf/bmjgh-2016-000249.pdf [https://perma.cc/6BUY-RF55].

443. *See* Economic and Social Council, *supra* note 392, ¶ 1.

444. *See* Wamalwa, *supra* note 21, at 3–4.

445. *See* ANNIE KEARNS, SAKI ONDA, PETRA TEN HOOPE-BENDER, OZGE TUNÇALP, JACQUELYN CAGLIA & ANA LANGER, JACARANDA HEALTH: A MODEL FOR SUSTAINABLE AFFORDABLE HIGH-QUALITY CARE FOR NAIROBI'S LOW-INCOME WOMEN 2 (2014), https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH-Jacaranda3rev.pdf [https://perma.cc/34SP-6RB4].

446. *See* Economic and Social Council, *supra* note 392, ¶ 36.

447. *See* Brian Barasa Masaba & Rose M. Mmusi-Phetoe, *Free Maternal Health Care Policy in Kenya; Level of Utilization and Barriers*, 13 INT'L J. AFR. NURSING SCIS., Aug. 6, 2020, at 1, https://reader.elsevier.com/reader/sd/pii/S2214139120301116?token=FF096901455353899E33D90DCD79BB779F07B00B0249C0C0E1F4CDC528D7AB422B8DFFFEBDDBF6FDA028E438B8BA47D9 [https://perma.cc/JMQ6-SU55] (describing the transfer of funds to NHIF).

448. *See* DEVELOPMENT INITIATIVE, A SUMMARY OF KENYA'S BUDGET 2017/18 WHAT'S IN IT FOR THE POOREST PEOPLE? (2017), http://devinit.org/post/a-summary-of-kenyas-budget-201718-from-a-pro-poor-perspective [https://perma.cc/E5V5-XVP3].

449. *See* Economic and Social Council, *supra* note 392, ¶ 33.

450. *See* ICESCR, *supra* note 380, at art. 2(1).

areas.[451] Kenya must be committed to ensure maximum utilization of its available resources towards achieving progressive realization of the right to health for women living in the informal settlements.[452]

C. Increasing Accountability and Transparency in Resource Allocation

The county and national governments should establish a monitoring and evaluation procedure to monitor the implementation of the free maternity program.[453] This will ensure transparent tracking of the results of the free maternity program and the resources allocated towards its implementation.[454] There is a need to enhance monitoring and evaluation of the free maternity care to include accountability and transparency mechanisms that will minimize the potential for fraud.[455]

Following the devolution of the health sector, the county governments must take appropriate measures to ensure maximum utilization of its available resources to advance the health rights of women living within its boundaries, including those in the informal settlements.[456] The county governments need to ensure health facilities, medical supplies and equipment needed are available and adequate to cope with the increased demand for maternal health services in the informal settlements.[457] This is essential to reduce the heath disparities between the urban rich and the poor women living in the informal settlements.[458]

The international human rights law promotes civic engagement and political accountability, both of which may stimulate the national and county governments to meet the health needs of its citizens, including the marginalized populations.[459] International human rights law is a catalyst for health equity in many countries.[460]

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451. *See* Gitobu et al., *supra* note 153, at 5, 7.

452. *See id.* at 7.

453. *See* Heidi W. Reynolds & Elizabeth G. Sutherland, *A systematic approach to the planning, implementation, monitoring, and evaluation of integrated health services*, 13 BMC HEALTH SERVS. RSCH., May 6, 2013, at 2, https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-13-168 [https://perma.cc/7RKM-ALT5].

454. *See* Tama et al., *supra* note 20, at 613.

455. *See* FAILURE TO DELIVER, *supra* note 4, at 13.

456. *See id.*

457. *See* Evelyn Kabia, Rahab Mbau, Robinson Oyando, Clement Odour, Godfrey Bigogo, Sammy Khagayi & Edwine Barasa, *"We are called the et cetera": experiences of the poor with health financing reforms that target them in Kenya*, 18 INT'L J. EQUITY HEALTH, June 24, 2019, at 12, https://equityhealthj.biomedcentral.com/track/pdf/10.1186/s12939-019-1006-2 [https://perma.cc/9PGM-38SM].

458. *See* Fotso et al., *supra* note 416, at 429.

459. *See* WHO, THE RIGHT TO HEALTH: FACT SHEET NO. 31 7 (2008), https://www.ohchr.org/Documents/Publications/Factsheet31.pdf [https://perma.cc/5U8M-2Z23].

460. *Id.*

D. Strategic Litigation for Maternal Health Rights for Women in Urban Informal Settlements

Maternal health rights are nonnegotiable and essential for the exercise of other human rights.[461] Every Kenyan woman is entitled to the enjoyment of the highest attainable standard of maternal health conducive to living a life in dignity.[462] The realization of the right to health may be pursued through the adoption of specific legal instruments which are enforceable.[463] There is need to eliminate discrimination against poor women living in the informal settlements regarding their access to high quality and affordable maternal health care, including sexual and reproductive services.[464] Strategic litigation on the inalienable right to the highest attainable maternal health care[465] would contribute in reducing maternal mortality and improving maternal health status of many women living in the urban informal settlements.[466] Kenya is obligated to ensure the right of access to quality maternal health services on a non-discriminatory basis, especially for vulnerable or marginalized groups, including women in the informal settlements.[467] The government is mandated to ensure equitable distribution of health facilities[468] and adoption of specific national policy guidelines on the free maternity care, on the basis of epidemiological evidence.[469]

The Kenyan government cannot justify violations of its core obligation of ensuring equitable distribution of health facilities, skilled personnel, and medical supplies in the informal settlements.[470] Similarly, misappropriation of health funds that would have otherwise supported the free maternity care violated the government's obligation to fulfill health rights for women.[471] Therefore, the civil society and human rights organizations can pursue legal mechanisms to hold the government accountable to its commitment towards realization of marginalized women's health rights.[472] Individual members of the public can also complain to the Special Rapporteur regarding their

461. *See* Economic and Social Council, *supra* note 392, ¶ 1.
462. *See id.*
463. *See id.* ¶ 2.
464. *See id.* ¶ 21.
465. *See id.* ¶ 1.
466. *See id.* ¶ 21.
467. *See* Economic and Social Council, *supra* note 392, ¶ 43(a).
468. *Id.* ¶ 43(e).
469. *Id.* ¶ 43(f).
470. *See id.* ¶ 47.
471. *See id.* ¶ 52.
472. *See id.* ¶ 1.

country's non-compliance to the ICESCR.[473] The Special Rapporteur can then invite the government to respond, seek information and where appropriate, recommend steps to correct the violation.[474]

CONCLUSION

For a long time, women living in Kenya's informal settlements have faced marginalization with regard to access to maternal health services.[475] It is imperative for the government of Kenya to take immediate steps to realize the maternal health rights for this vulnerable group of women. There is need for the national government to adopt a specific policy on free maternity care that will spell out the services to be provided free of charge to all women. The county governments must increase budgetary allocation towards the free maternity care and increase transparency and accountability in maternal health resource allocation and utilization for the benefit of women living in informal settlements. Further, the county governments are obligated to improve the public health facilities in the informal settlements so as to improve maternal health outcomes in these areas.[476]

473. *See Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, *supra* note 399.

474. *See* GOSTIN, *supra* note 286, at 259–60.

475. *See* Fotso et al., *supra* note 416, at 430, 437.

476. *See* Beatrice Odallo Evenlyne Opondo & Martin Onyango, *Litigating to ensure access to quality maternal health care for women and girls in Kenya*, 26 REPROD. HEALTH MATTERS 123, 124–26 (2018), https://www.tandfonline.com/doi/pdf/10.1080/09688080.2018.1508172?needAccess=true [https://perma.cc/HQ5B-9JQY].