

**REPRODUCTIVE HEALTH CARE OF WOMEN  
INMATES: A CASE STUDY OF LANG'ATA  
MAXIMUM WOMEN'S PRISON.**

**BY**

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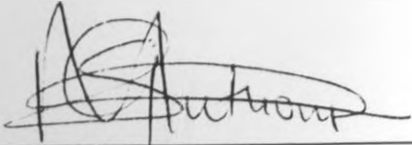
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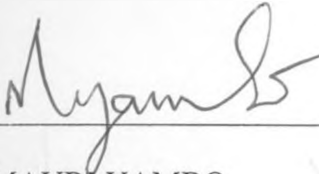
This project is my original work. It has not been submitted for a degree in this or any other University.



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This project paper has been submitted for examination with our approval as the University supervisors.

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## **DEDICATION**

Dedicated to the memory of my brother  
Tom Wanyeki Mugwe (1971-1996).

## ACKNOWLEDGEMENT

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*ASANTE SANA*

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## ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APHRC	African Population Health Research Center
CESCA	Conference for Eastern, Southern and Central African Heads of Correctional Services
CBO	Community Based Organization
DFID	Department for International Development
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
KANU	Kenya African National Union
KDHS	Kenya Demographic Health Survey
KHRC	Kenya Human Rights Commission
MOH	Ministry of Health
NGO's	Non Governmental Organizations
PATH	Program for Appropriate Technology in Health
PC	Population Council
PRI	Penal Reform International
STIs	Sexually Transmissions Infections
TBAs	Traditional Birth Attendants
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
WHO	World Health Organization



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## ABSTRACT

A woman's health and nutritional status is both a national and an individual welfare concern. This is because it affects the next generation, through its impact on her children, as well as her productivity at the household level and in the wider economy. When mothers are malnourished or sickly, or when they receive inadequate prenatal and delivery care, their children face a higher risk of disease and premature death

The study was designed to investigate what forms of reproductive health care interventions are offered to women inmates at Lang'ata Maximum Women's Prison. More specifically, the researcher sought to describe the availability and utilization of reproductive health services at the prison and assess and determine the quality of reproductive health care services there in. It was also imperative for the study to identify gaps in the delivery of reproductive health services at the prison.

Conditions in African prisons are life threatening and a potential health hazard to prison population. Morbidity and mortality rates are high and health status is worse in prisons than in the general community. By 2001, Kenya had a prison population of 40,000 inmates made up of convicts on remand and those who had been sentenced to serve time. In particular, there has been a dramatic growth in women's prison population in Kenya against non-growing facilities to match the same. It is no secret, as evidenced by the regular reports in the media, that the state of Kenyan Prisons is deplorable, and that the prisons are congested beyond their holding capacity. The sight of inmates gives a picture of a dejected, deprived, neglected, if not almost forgotten, lot.

The research focused on women inmates within the reproductive age of 15-49years. There were three different categories of women inmates, namely; pregnant, lactating and other general inmates. Information from the field was collected by use of interview schedules and use of interview guides for the key informants. An observation check list was used to assess the equipments available within the prison clinic. Data analysis was done using SPSS. Research questions were adequately answered through summaries in the form of percentages and frequency tables.

The study revealed that a few reproductive health interventions were being availed to the inmates. These were pre-natal, post-natal care, treatment of STIs and HIV/AIDS, immunization programmes for children and health information. A healthy woman requires an all round care provision. It is however interesting to note that out the interviews conducted, the majority of inmates were somehow contented with the services since they indicated the services were average.

The quality of reproductive health care is way below the internationally/nationally recognized standards. Women constitute a special category of vulnerable prisoners. Facilities like delivery kits are lacking and nurses handle all cases that require medical attention. These include but not limited to emergencies like deliveries which are ordinarily referred to Kenyatta National Hospital.

There are too few staff to meet physical health needs. The time allocated for clinic visits is rather too short to have all clients given ample time for diagnosis. Everything is then handled in a hurry and quality of service is questionable. This often results in long delays in obtaining medical attention. The infirmary in the prison served both the inmates and the staff therein. This overstretched the facility in terms of staff and drugs to the detriment of the inmates.

The key informants informed the study that there is no medical officer based at the prison and their visits were unpredictable. In standard practice, Medical Officers are supposed to diagnose and prescribe drugs for patients. Lack of Medical Officers implies that patients are treated by nurses who the researcher found on duty through out the study period.

Among the recommendations proposed by the study are establishment of a Comprehensive Female Health Care System, development of programmes of sanitary education including being open to NGOs and well wishers as well as encouraging private/ mobile clinics.

# CHAPTER 1: INTRODUCTION

## 1.1 Background

Reproductive health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions and processes (International Conference on Population and Development ICPD, 1994:2). It is a crucial aspect of general health and is central to human development. Reproductive health is internationally understood to be a cornerstone of sustainable development. In many countries, the need for governments to focus on reproductive health has never been greater especially with the growing pandemic of HIV/AIDS and sexually transmitted infections. (ICPD, 1994).

Prior to the 1978 Alma Ata Declaration, health services in Kenya were mainly curative with little emphasis on preventive obstetrics and maternal child health services (Republic of Kenya, 2002:1). Family planning services were at infancy at the time of declaration. A decade later, a global review of the impact showed remarkable improvement in child health and to a lesser extent family planning services. International concern on continued high rates of maternal mortality and gender disparities led to the adoption of the global reproductive health approach at the ICPD programme of action, Cairo in 1994. This called on member states to pay more attention to adolescent health complications of abortion, cancers of the reproductive system, management of infertility, gender issues such as rape and domestic violence, FGM, and STIs including HIV/AIDS. In an effort towards achieving this state, Kenya developed a National Reproductive Health Strategy 1997-2010 as a product of district plans to cover all provinces. The government of Kenya thought it would achieve equitable distribution of service delivery and adopt an integrated comprehensive reproductive health system (Republic of Kenya, 2002:2).

Reproductive health care in Africa is an important subject and a relevant area of specialty. Sub-saharan Africa is faced with high levels of unwanted pregnancies, high levels of maternal, child and infant morbidity and mortality and an almost exponential growth in HIV prevalence. Access to and quality of reproductive health services remains

poor in most countries, thereby maintaining unmet need for even the most basic reproductive health services (USAID and Population Council, 1998:7).

In Kenya, there are 89 adult prisons and three corrective centres for those who are eighteen years and below. The gazetted women's prisons number 13 country wide. Lang'ata Maximum Women's Prison was established in early 1940's as a detention camp for women (Daily Nation, February 26, 2003). Fifteen years later, it was gazetted as a women's prison and remains the only women's maximum security prison. It is worthwhile noting that since then only the administration block has been built. It stands on a one-hundred-and-four acre plot. Women all over the country serving seven years and above are transferred there (Daily Nation, February 26, 2003).

Despite impressive improvements in the health situation of mothers and children in the past decade in many developing countries, levels of maternal, infant and childhood mortality and morbidity remain appallingly high (Burkman and Magarick, 1988:4). The Kenya Demographic and Health Survey (2003:114) reveals that the under five mortality has increased from 110 deaths per 1,000 live births in the period 5-9 years before the survey (1993-1997) to 115 deaths per 1,000 live births for the period 0-4 years before the survey (1998-2003). This means that one in every nine children in Kenya dies before his/her 5<sup>th</sup> birthday.

Similarly, there is a substantial rise in adult mortality since 1998 (KDHS, 2003:237). At younger ages of 15 to 34 years, women's mortality is higher than men's, most likely due to HIV/AIDS. Maternal mortality rate was 414 maternal deaths per 100,000 live births for the ten-year period prior to the 2003 survey. Currently maternal deaths account for 15 percent of all deaths to women aged 15 to 49.

## **1.2 Problem Statement**

A woman's health and nutritional status is both a national and an individual welfare concern. This is because it affects the next generation, through its impact on her children, as well as her productivity at the household level and in the wider economy. When mothers are malnourished or sickly, or when they receive inadequate prenatal and delivery care, their children face a higher risk of disease and premature death (World

Bank, 1994:6). Concern about reproductive health care is becoming increasingly relevant in Kenya as indeed, according to the National Reproductive Health Training Plan for the period 2000-2004, all reproductive health programmes were specifically geared towards meeting the needs of individuals and providing comprehensive and quality health services. This called for an integrated approach to ensure the provision of reproductive health services, defined for each level of health care system, on all days, during the same visit and where possible by the same provider (Republic of Kenya, 2000:2).

The quality of reproductive health care at the service delivery points is often not known (DFID, 2002:1). The existence of such health care facilities tells very little about their efficiency, effectiveness and efficacy. Facilities may lack or have inadequate basic resources such as drugs, means to measure blood pressure, and water. Reproductive health equipment may be in short supply as well. These include: ambulance for emergency obstetric cases, delivery rooms with beds and well-lit labour rooms. Similarly, certain reproductive health services are provided only in a handful of health facilities (APHRC&PC: 2001:36). Such services include vacuum extraction, termination of pregnancy on medical grounds, management of incomplete abortion and postpartum care of mother and baby (see also DFID, 2002:2).

Conditions in African prisons are life threatening and a potential health hazard to prison population. Morbidity and mortality rates are high and health status is worse in prisons than in the general community (Penal Reform International, 1999:3). Similarly, the Human Rights Commission report on Kenyan prisons says there is acute shortage of ante-natal and post-natal care for pregnant and nursing mothers (KHRC, 2002:55). According to the report by the Penal Reform International (PRI), access to health care in African prisons is difficult and as much as special care is needed for the vulnerable, such as women and children, the penitentiary system is not adapted to their needs (PRI, 1993:4). All maternity cases except emergencies that could be handled by nurses, are referred to district hospitals as there are no delivery kits in prisons.

By 2001, Kenya had a prison population of 40,000 inmates made up of convicts on remand and those who had been sentenced to serve time (KHRC, 2002:13). In particular,

there has been a dramatic growth in women's prison population in Kenya against non-growing facilities to match the same (Daily Nation, 18<sup>th</sup> June, 2003). It is no secret, as evidenced by the regular reports in the media, that the state of Kenyan Prisons is deplorable, and that the prisons are congested beyond their holding capacity (Daily Nation, 4<sup>th</sup> June, 2003). The sight of inmates gives a picture of a dejected, deprived, neglected, if not almost forgotten, lot.

Incarcerated women further face their own unique health problems such as peri-natal issues and sexual harassment or abuse from guards (Ammar and Erez, 2000:19). Women inmates suffering from treatable diseases such as late term miscarriages and cancers have little or no access to medical attention, and this sometimes results in death or permanent injury (Ammar and Erez, 2000:19). In their study of health care delivery systems in prisons of Ohio, Ammar and Erez noted instances of failure to deliver life-saving drugs to inmates with HIV/AIDS, especially during times of pregnancy. Half of the state prison systems surveyed offered female-specific services such as mammograms and pap smears, but these often entail long waiting periods.

A reproductive health needs assessment by African Population and Health Research Center and Population Council, (APHRC&PC, 2001:12) in eight selected districts of Kenya concedes that providing reproductive health in Kenya, especially in rural areas, is a great challenge. It says that over 50 percent of the births are delivered by traditional birth attendants (TBAs), relatives and neighbors outside health facilities. Only when complications develop are women referred to health facilities. Some women prefer traditional healers in some cases to health clinics as they are cheaper. The majority of women and men alike seem not to appreciate the important role played by delivery and postnatal care. Reproductive health care is therefore an important area of focus.

A study on Nairobi's slum dwellers' reproductive health and livelihood shows another insight into the inadequacy of health facilities (Wasao and Bauni, 2001:13). There are few maternal and child health facilities and many mothers have no access to prenatal or postnatal care, or immunization for their children. Sexually transmitted infections (STIs) like HIV/AIDS, gonorrhoea and syphilis are common and spread rapidly. However, it is



possible that it is not only the inadequacy of health facilities that inhibits access and utilization of such facilities. Women in the informal settlements may as well be ignorant of such services. Other factors, such as the cost involved, levels of education and religion, may hinder women from seeking health care services.

After the change of government in Kenya from KANU to NARC, in January 2003, several initiatives have been launched to make Kenyan prisons more rehabilitative than punitive. "Prisons have for long remained a closed shop and time has come for prison officials to open them up to the Public" (Daily Nation, 27<sup>th</sup> April 2004). According to Kenya Human Rights Commission, little research has been conducted on Kenyan Prisons as they have been inaccessible to outsiders (KHRC, 2002:1). The researcher therefore anticipated that the study will reveal the availability, utilization and quality of reproductive health care among women incarcerates, identify gaps and put forward plausible recommendations for effective and efficient health care services.

### **1.3 Objectives of the Study**

The overall objective of this study was to investigate what forms of reproductive health care interventions are offered to women inmates at Lang'ata Maximum Women's Prison. More specifically, the study sought to:

1. Describe the availability and utilization of reproductive health services at Lang'ata Maximum Women's Prison.
2. Assess and determine the quality of reproductive health care services within the prison.
3. Identify gaps in the delivery of reproductive health services at the prison.

### **1.4 Scope and Limitations of the study**

The study was limited to Lang'ata Maximum Women's Prison in Nairobi Province. This is the largest women's prison in Kenya. It is also the only maximum women's prison in Kenya where all women with capital offences are transferred. The study focused on the availability, utilization and quality of reproductive health care interventions as well as the institutional capacity of the health care facility at Lang'ata Maximum Women's Prison.

It was an attempt to investigate the extent to which women given maximum prison sentences in Kenya have reaped the benefits of the “health for all” initiative.

Due to time constraints and nature of respondents, this study fell short of getting the right sample size in the category of lactating and pregnant inmates. The study only managed to interview 20 lactating and 15 pregnant inmates out of a target of 30 for each cohort. Those were the only respondents who met the eligibility criteria at the time of the study. The study had set out for a higher sample size than was actually available. However, it was still possible to generalize the findings based on the fact the target inmates were not available at the time of the study.

## CHAPTER 2: LITERATURE REVIEW

This chapter reviews available literature, identifies gaps and subsequently presents research questions. The proposed study is an exploratory one as the researcher is not aware of any reproductive health care studies in Kenyan Prisons.

### 2.1 Major Causes of Maternal Morbidity and Mortality

Abortion, Cancer of the Cervix and Breast, Ill health and mortality during maternal period, STIS and AIDS and contraception are some of the major crises in women's reproductive health. Of the annual total of 500,000 maternal deaths that occur each year, most are in developing countries (WHO, 1994:1). According to World Bank, (1994:1), Sub-Saharan Africa has the world's highest maternal mortality rates, which are exacerbated by poor prenatal and delivery care. In Kenya, the major causes of mortality and morbidity in women are closely tied with their reproductive health (Ngacha, 1998:4). He says that many women continue to die from pregnancy-related complications which could be prevented through use of simple and inexpensive technology. Lowenson (1993:11) notes that maternal mortality in sub-Saharan Africa is often the result of inaccessibility of health services and the failure of antenatal services to identify 'at risk' patients. However, millions of women survive pregnancy complications but nonetheless suffer acute or chronic ill-health or life-long disabilities. Complications that affect women during pregnancy and childbirth affect the fetus as well. According to WHO, around 8.1 million infants die each year, one third of them within the first month of life and a large proportion within a few days of birth. WHO (1994:1) observes that many of these neonatal deaths are a direct consequence of poorly managed pregnancies and deliveries. Millions of infants survive but with a degree of damage that renders them physically or mentally disabled throughout their lives (see also Kinoti, 1993:25).

Abortion remains illegal in Kenya but this law is freely broken and abortion services are readily available. Print and electronic media reports in Kenya on aborted fetuses are just a tip of the iceberg. Results of a 4-year survey on reproductive health needs in East, Central and Southern Africa revealed that abortion is of major concern in causing

morbidity and mortality (Kinoti, 1993: 22). The study showed that increasing incidence of premarital pregnancy, especially affecting school-age teenagers, is associated with a similarly high incidence of septic abortion and contributes significantly to maternal mortality (see also World Bank, 1994:52). With lack of legalized abortion and inadequate access to professional management, mortality due to septic abortion will remain high. According to Lee (1994:4), unsafe abortion alone kills as many as 200,000 women globally each year, 99% of them in developing countries. Similarly, WHO says that, of the 150 million women who become pregnant each year world wide, half a million die from pregnancy-related causes and another 62 million suffer long-lasting debilitating effects (WHO, 1994:4).

Cervical cancer was recognized as a serious health problem in Kenya, accounting for 8 to 20 percent of all cancer cases in the country in the 1980's (PATH and KMWA, 1998:4). Cancer of the cervix is responsible for serious morbidity and mortality among women, and it has been shown to occur among young women in their twenties and thirties in the East, Central and Southern African region (Kinoti, 1993:25). He notes further that in Kenya there are inadequate facilities for treatment of this form of cancer and services like pap smears are not taken at all in many health care facilities due to lack of trained manpower and equipment. The PATH and KMWA report reveals that though the average age of diagnosis is 42 years, cervix cancer is known to occur among young women in their twenties and thirties in Kenya. The fact that women usually present with advanced diseases, cervical cancer is recognized as having significant social and economic costs in Kenya. Even when cancer is diagnosed early, the treatment of choice radiotherapy is only available at one public hospital that is Kenyatta National Hospital, and one private hospital, the Nairobi Hospital. Moreover, radiotherapy is availed at a cost beyond reach to many seeking the service.

It is of great concern that 90% of the women admitted to Kenyatta National Hospital with cancer of the cervix have had no regular gynecological screening (Ngacha, 1998:2). Most women at Kenyatta National Hospital present with advanced disease and have never heard of Pap smear examinations. According to PATH and KMWA, cervical cancer is a serious enough health problem to warrant significant investment of resources.

The women interviewed had difficulties talking about the signs and symptoms of cervical cancer. They were not comfortable talking about pelvic exams either. Interestingly, several health care providers particularly in the rural setting did not know the purpose of a pap smear. The same situation is confirmed by the Population Council, Catholic Diocese of Nakuru and UNFPA in their study of health care facilities managed by religious institutions, NGOs and CBOs in Kenya (2001:27). Services like pap smear are not offered and where offered, cost Kshs 500, which is not affordable for many women. It was evident that there is scanty information passed on these reproductive health cancers. The health talks provided at clinics are usually on family planning, nutrition and more recent on AIDs but not cancers.

Rates of cancer of the breast are also on the increase in recent years (Kinoti, 1993:25). However, he notes that with early detection and appropriate treatment, breast cancer could be permanently cured. Women in Sub-Saharan Africa tend to develop breast cancer 10-15 years earlier than their western counterparts and have totally dissimilar associated risk factors (Muhombe, 1998:173). What is surprising is that none of the countries of East, Central and Southern Africa have an operational nation-wide cancer registry.

The emergence of HIV/AIDS, its rapid spread and its health and social consequences have introduced a new and very serious dimension to problems caused by Sexually Transmitted Infections (Wasao and Bauni, 2001:13). In their study of Nairobi's slum dwellers, they found that people infected with HIV/AIDS fail to get treatment immediately, others may not be aware that they are infected or may be embarrassed to go to hospital, yet others get incomplete treatment. Slum dwellers are said to have inadequate knowledge on STIs and their impact on general health. The high levels of STIs and AIDS in the slums may be attributed to widespread prostitution and many residents having multiple sexual partners. In Kenya, most women go to healthcare facilities to seek services related to safe motherhood and child survival. Despite this, there is very little preparedness at the institutions in the way of provider competence (few professionals and other health providers, no updates in safe motherhood and no desire for its training among providers). Too often, the tendency has been to focus on women's

reproductive health or otherwise on mothers in general leaving out a huge part of the female life cycle. The researcher is of the opinion that obstetrical assistance is only geared towards pregnancy and its outcome but not the entire woman both in her reproductive and menopausal age.

## **2.2 Utilization of Reproductive Health Services**

Whether a woman makes use of the available health services or not depends to a larger extent on her own perceptions of her symptoms (Khatab, Nabil and Hunda, 1999:62). In their study conducted in rural Egypt, Khatab, Nabil and Hunda (1999:63) found that women's perceptions of their symptoms are to a large extent formed by cultural and socio-economic circumstances. Perceived infertility or delayed conception resulted in the highest proportion of physical consultations of 54%. This greater frequency of health care consultation for perceived infertility relative to other conditions illustrates the overriding physiological, social and cultural importance attached to fertility in rural Egypt.

However, Population Council, Catholic Diocese of Nakuru and UNFPA (2001:43) found that most women go to health care facilities to seek services related to safe motherhood and child survival. Among the patients who visited religious health institutions, about two thirds of them sought services as follows: 47.4% percent for child welfare, 17.3% for antenatal care and 2.3% for maternity services. In NGO- and CBO- managed institutions, it was found that safe motherhood and child survival take about 70% of the demand for reproductive health services. This was as follows: 43.1 percent for child welfare, 24.7% for antenatal care and 1.7% for maternity (PC, CDN and UNFPA, 2001:43).

According to the KDHS (2003:11), almost 90% of Kenyan women receive antenatal care from a member of the medical profession: 18% a doctor, 70% from a nurse or midwife and 10% receive no antenatal care at all. In Nairobi, for example, only 4% of women receive no antenatal care compared with 68% of women in North Eastern Province. Lack of education and costs involved are said to restrict access to health care. Indeed, according to APHRC and Population Council (2001:12), women in rural Kenya in some

cases prefer traditional healers who are cheaper and readily accessible. Proper antenatal care can reduce the level of neonatal mortality (KDHS, 2003:11). It is recommended that mothers receive antenatal care within the first three months of their pregnancy. In Kenya, only 11 percent of women had an antenatal care visit by their fourth month of pregnancy. According to the 2003 KDHS, only 52 percent of pregnant women received the recommended two doses of tetanus injection and only 3 percent took iron tablets for the recommended duration during pregnancy.

The inter-relationship between women's low status and their access to health care is a complex one (WHO, 1994:2). Health care for women is both the outcome of their status in society and a determinant of their health and productivity and ultimately of their status. Pregnancy-related deaths and disabilities result not only in human suffering but also in losses to social and economic development (WHO, 1994:10). Women who die are in the prime of life, responsible for the health and well-being of their families. They generate income, grow and prepare food, educate the young, and care for children, the elderly and the sick. Their deaths represent a drain on all development efforts. In their study, Khattab, Nabil and Hunda (1999:69) found that women assign low priority to their own health as compared to the needs of their families. Their own personal needs, such as dietary requirements, are put after those of their children, husbands and sometimes other family members. For instance, after a woman called "Sanar" had surgery, the researcher noticed that she was not following nutritional guidelines recommended which should have provided her with the essential vitamins and proteins to hasten the healing of the wound. She asked "How can I eat meat, chicken and eggs with my children looking on?" (Khattab, Nabil and Hunda 1999:69).

User fees reduce attendance, thereby impacting negatively on reproductive health (Berer, 1993:3). In his report on African Reproductive Health Matters, he notes that there are few countries where access to contraception is free and treating infertility is considered a luxury. He points out that people cannot be blamed for not using available services, 'one needs to look at whether the available services are appropriate, what people want and think, how much information people have, and what would make services more useful particularly to women' (Berer,1993:4). Indeed, according to the World Bank (1994:6),

the infrastructure facilities are said to influence access to health care services. It is aptly put that the general level of underdevelopment may pose additional health risks for women. Poor roads and lack of them, as well as inadequate obstetric facilities, hinder women from receiving timely medical treatment for pregnancy-related complications.

In countries where women are less educated, receive less information than men and have less control over decision making and family resources, they are also less likely to recognize or to seek health care (World Bank, 1994:6). Cultural factors, such as restrictions on women travelling alone or being treated by male health care providers, restrict women's use of health services in some Middle Eastern countries. However, a study conducted in Maragua district of Central Kenya gave a different line of opinion. In her study, Njoroge (2005:49) found that women failed to attend pre natal care for several personal reasons, among them: embarrassment, abuse from attendants and religious persuasion. The very young and old mothers were found to be less likely to seek pre natal care due to their reluctance to disclose the pregnancy and their inclination to shy away from the public eye. They mostly sought care when they felt sick or only when they were in need of a pre natal clinic card which was required at the time of admission to hospital (Njoroge, 2005:49).

In a study conducted in Machakos by WHO, UNICEF, and UNFPA (2001:13), it was found that women may be intimidated by the staff and atmosphere in health institutions. The facilities known for mistreating women are likely to be under-used. However, the majority of women, irrespective of where they chose to deliver, attended prenatal clinics at the nearest hospitals, at least once during pregnancy. When asked during pregnancy, 56% of the women stated that they intended to deliver in hospital but only 26% ultimately did so. Hospital delivery was seen to be dependent mostly on opportunity and habit (WHO, UNICEF, UNFPA, 2001:124).

Qualitative findings of the study by Population Council, UNFPA and Catholic Diocese of Nakuru in Kwale and Longonot showed that nature of help sought was heavily dependent on external and local factors although women recognized there were real and potential problems that come with pregnancy and delivery (2001:17). Deliveries were mostly



conducted at home unless there was a complication. Transport cost and the long distances to the health care facility were an impediment to full utilization of the facilities. A study in Kisumu by the same revealed a different scenario: some women preferred to deliver at the hospital given that 'there is least care at home in this era of HIV/AIDS' (PC, UNFPA and CDN, 2001:17). In Kisumu, TBAs were said to be getting expensive by the day yet mothers were supposed to have purchased all the required tools and items during delivery. Home deliveries were shunned because of poor hygienic standards; one woman in Kisumu reiterated 'you are given a dirty sack to lie on at the back of her house where you are also exposed to cold and insect bites'.

Studies in Zaire and Ethiopia offer further interesting insights into why women might stay away from maternity facilities (WHO, UNICEF, and UNFPA, 2001:13). In the Zaire study, 13 of 20 maternal deaths occurred during the first 5 months of planting and harvesting seasons when women were busy in the fields and were reluctant to take time off. Researchers in Ethiopia found that 60% of those who did not seek prenatal care had unwanted pregnancies, and those women with unwanted pregnancies who did seek prenatal care tended to visit maternal and child welfare clinics that were free of cost (WHO, UNICEF and UNFPA 2001:13).

Khattab, Nabil and Hunda (1999:70) found that women consulted their husbands more than any other person as to whether to seek health care. However, these were women between 20 – 24 years. Very young married women (under 20 years) consulted other family members more often. Women did not have medicalized understanding of their bodies; they could see changes but were unable to identify them as symptomatic of a morbidity that needed attention. However, although reproduction is the result of physiological activity between biologically capable individuals, males and females, the burden of responsibility falls disproportionately on the female. It is the woman who carries the pregnancy to its outcome, who goes through childbirth, breast feeding, and child rearing and faces all related health problems and complications. She is charged with the responsibility of nurturing and general care of the family. This she does through her daily chores both domestic and otherwise outside the home. Their special reproductive

roles therefore demand greater health needs than men. Women cannot be expected to benefit from the general community health programmes.

The researcher is interested in finding out the health-seeking behaviour of women in prisons. Are incarcerated women influenced by the same factors as those outside prisons? Women inmates are separated from their husbands, older children and relatives and yet are not economically endowed, what then determines their utilization of reproductive health services?

### **2.3 Nature of Health Care Services**

In developing countries, the scope of reproductive health services to a large extent reflects past international concerns with family planning and maternal and child health (Khattab et al, 1999:70). Rural clinics are often identified with these services and as such seen as not inclusive and inappropriate for those who do not need contraceptives or are beyond childbearing years. During the International Conference on Population and Development (ICPD, 1994) in Cairo, it was universally recognized that there is need to widen the scope of reproductive health beyond fertility control to a broader concern for the individual needs of women regarding their reproductive health in general. A more holistic approach to women's health is needed which takes into account the socioeconomic as well as cultural constraints that women face in accessing health care.

Health service delivery in Kenya is mainly undertaken by the Government through the Ministry of health and NGOs (Ngacha, 1998: 12). These provide 60% and 40% of the services respectively. Ngacha notes that the contribution of traditional healers and herbalists has not been evaluated though their contribution in the provision of health care services is significant in some rural areas. A reproductive health needs assessment by the Ministry of health revealed that the current referral system is inadequate as is demonstrated by lack of communication facilities (telephone, radio), emergency transport as well as unskilled relatives accompanying mothers with obstetrics emergencies (Republic of Kenya, 2002:61). The report reveals that there is inadequate collaboration, coordination and linkage between the MOH, other sectors and its partners in reproductive

health matters. Similarly, the traditional birth attendants have limited knowledge on warning/danger signs during pregnancy, delivery and post delivery.

Kenya's public health care system has been infiltrated by unethical practices like deliberate delays in the provision of health care to soliciting payments/bribes for services (Republic of Kenya, 2002: 61). Health facilities visited during the reproductive health needs assessment lacked absolute minimum equipment for delivery and care of new born such as delivery kits and oxygen cylinders.

Findings from a health needs assessment in eight selected districts of Kenya (APHRC and PC, 2001:12) show that nurses provide the bulk of the health personnel but are in short supply and are poorly distributed. There was an overall deficit of one hundred and sixty one nurses within the study area. Midwife nurses who are specially trained to deal with maternal and child health care were in acute short supply. On average, there were 6 midwife nurses per 10,000 women aged 15 to 49 years (APHRC and PC, 2001:30). The assessment's findings also showed that the Ministry of health has an uphill task in providing reproductive health services and that rates of infant, child and maternal mortality are rising. The Health and Demographic Survey (2003:18) corroborates the upward trend.

The provider/client interactions are said to be extremely brief, as short as a couple of minutes, and in many instances it is mainly limited to verbal questioning (Karima Khalil et al, 2000:16). Providers of health care often neglect to listen to the clients and fail to encourage them to ask questions. Providers also do not explain treatment procedures properly and fail to make sure that the clients understand them. Findings from a health needs assessment in Kenya by PC, UNFPA, and CDN showed that provider attitude and general atmosphere at the health facility did keep women away who would otherwise use the services (2001:18). This was so if one had many children and often one had to cheat before delivery that it was first or second child, only to disclose later how many other children she already had.

Those who design health services do not take enough care to make them convenient or culturally acceptable to women (WHO, UNICEF and UNFPA, 2001:13). In the same

study it was found that clinics in rural areas where sexual taboos were strong, were actually staffed predominantly by men. This resulted in underutilization of such facilities. A hospital study by the same cited avoidable factors as causes of maternal deaths. These included late referrals making women arrive at the referral centre in a poor condition, poor patient management, lack of proper investigations and decisions about operative interventions being taken too late (WHO, UNICEF and UNFPA, 2001:127). Coming closer home, the study findings revealed that there were inadequate facilities at Kenyatta National Hospital. The facilities were far from adequate to meet the inflow of obstetric patients. There was overcrowding, patients shared beds and mattresses, exposing them to cross-infections within the hospital. The linen and basic equipment such as gloves were not enough (WHO, UNICEF and UNFPA, 2001:127).

A study on prisoner health by Gill Hck, 2007, that interviewed a cross-section of 111 prisoners across the United Kingdom, revealed that policies and standards of healthcare really varied from prison to prison. Inmates lacked privacy and confidentiality with some prisoners having to discuss problems like sexually transmitted diseases in front of other inmates. A number of prisoners also complained that they were treated according to prison rules, not on the advice of healthcare specialists, including hospital consultants and that meant being denied certain types of medication. There were long waits to see doctors which usually required written applications or requests by the inmates. Other prisoners expressed concern that night-time health emergencies would not be handled promptly, saying that they were banned from sounding their buzzers after lock-in and that doors were only unlocked in the most serious circumstances.

Few resources are dedicated by governments to African prisons to cater for health and adequately trained personnel are lacking (Penal Reform International, 1999:3). According to the report by Penal Reform International, there are structural problems in prison health care facilities among them: poor record keeping, patients' lack privacy and confidentiality, systems' lack of transparency and lack of incentives to attract doctors to work therein. Access to health care is difficult, drugs and equipment are lacking. Indeed, the prison population is said to be poorly informed about health care, infectious diseases and STIs. The report attributes high prevalence levels of HIV/AIDS in African prisons to

lack of information. Prisons have no facilities either for the terminally ill, and the screening process is unsatisfactory (PRI, 1999:4). In fact, according to a report of the fifth conference of the Eastern, Southern and Central African Heads of Correctional Services (CESCA, 2001: 6), HIV/AIDS in prisons is a national calamity. Among its deliberations, CESCA recommended the use of mobile health services, both private and public, compulsory ante-natal services and, where possible, non-custodial services for pregnant mothers (2001:50).

In Kenya, the Prison Department does not have its own doctors but relies on the Ministry of Health (Kenya Human Rights Commission, 2002:26). Due to the existing shortage of government doctors, prisons only manage to receive occasional visits from a professional. The infirmaries therein serve both staff and inmates, thereby overstretching the facilities in terms of staff and medicine, to the detriment of inmates. Prisons were characterized by long queues at the dispensaries with some incarcerates too weak to stand. Most prisons visited by the Kenya Human Rights commission lacked transport to take patients to referral hospitals, and lacked laboratories as well as testing kits for HIV/AIDS. The report further said that dispensaries lacked drugs and pain killers were given for any ailment. Regrettably, it is only in an epidemic situation that public health authorities divert their attention to institutions like prisons. At other times, they are neglected and forgotten places. Similarly, there were no sick bays where patients could be provided with special care (KHRC, 2002:26). The report recognizes that women constitute a special category of vulnerable prisoners where women inmates with infants and young children should be allowed to keep them and be provided with special facilities. The minimum standards for the treatment of prisoners are those that are generally accepted as being 'good principles and practices' (PRI, 1999:15). Health in prison should be a matter of constant concern for African States.

In Kenya, women and sick inmates face untold hardships in prison cells. Pregnant women have no special diet; no antenatal or post natal facilities; and except emergencies, all cases are referred to government hospitals as there are no delivery kits in prison health centres (East African Standard, November 25<sup>th</sup> 2002). Prison inmates are subjected to the risk of infection from both severe and debilitating diseases, and those with no relatives or

money cannot access drugs, or proper bedding. The quality of food is poor and lacks nutritional value. Therefore, pregnant and lactating mothers are constantly exposed to deteriorating health conditions. However, the government has direct responsibility to ensure the availability of safe, effective, affordable and acceptable health to all citizens, including those incarcerated.

In the proposed study, the researcher intends to find out the real situation at Lang'ata Maximum Women's Prison. Are the health care facilities therein meeting the growing international concerns for quality reproductive health care? Do the reproductive health care services offered therein match International Standards? Do health care providers in Kenyan prisons take time to explain treatment regimens to the patients? What are the health care providers' attitudes towards their clients? What reproductive health information is availed to the inmates? What are the greatest health needs of the inmates?

### **Theoretical Framework**

All empirical studies should be grounded in theory (Singleton et al, 1988:140). A theory is a body of knowledge attempting to explain a given social reality. It is a way of making sense of a disturbing situation. It specifies the relationship between variables with the purpose of explaining the problem in question.

### **Systems Theory**

The aim of this section is to introduce the idea of systems theory and illustrate its application in health care provision. The social system is made up of the actions of individuals (Parsons and Shils, 1967: 190). Actions which constitute the social system are also the same actions which make up the personality systems of the individual actors. The two systems are however analytically discrete entities, despite this identity of their basic components.

Luhmann's General Systems approach stresses the fact that human action becomes organized and structured into systems (Turner, 1991:94). When actions of several people become inter-related, a social system can be said to exist. Systems thinking has over the past three decades emerged as one of the most important disciplines, providing a

powerful mental frame of reference in understanding problem solving situations and guidance for day -to -day decision making.

The origin of the term 'system' goes back to Greek antiquity, and today it is commonly used in natural, physical and social sciences (Abraham, 1981:39). A system consists of two or more units that relate to each other in a structural relationship and form an entity whose elements are functionally inter-dependent. In this study, the appeal of systems approach arises from its focus on how the parts of the process are dependent upon each other. It is necessary to understand the distinction between closed and open systems. A closed system is one that does not respond to events and occurrences outside the system. It cannot adapt to changes and is therefore predictable.

Health systems and health research should ideally be mutually dependent (WHO, 2004:5). A well functioning health system is critical to the development and delivery of interventions that affect public health and health outcomes. On the other hand, a strong health research system is important for an effective and efficient health system. Both systems are equally challenging to manage and difficult to describe. According to WHO, a health system includes all actors, organizations, institutions and resources whose primary purpose is to improve health. The effectiveness, efficiency and equity of national health systems are critical determinants of population health status. Health research system can be broadly defined as the people, institutions and activities whose primary purpose is to generate and apply high quality knowledge that can be used to promote and or maintain the health status of populations.

The incarcerated women's health-seeking behaviour is determined by a certain order and pattern therein. The prison's health care department is taken to be an open sub-system with open boundaries. This implies that its works are interrelated and interlinked to elements of other departments with the prison and beyond to make a perceived whole. This study is aimed at looking at the functionality of reproductive healthcare availed to women prisoners. Are the health care facilities under full utilization? What are the viable ways for improving operations within the facility? This will point out whether a systems design or systems improvement is the way forward.

### Situational Approach Theory

This theory was formulated by Znaniecki (1974). It looks at human behaviour as being determined by situations. Human situations and perceptions of situations are directed by biological, psychological, social-economic and cultural factors. These factors operating singly or combined can limit and determine the way an individual will behave. Women's health-seeking behaviour may be determined by the biological factors; psychological-attitudes towards a disease and ability to cure it; socio-economic- age, sex, education background, income, marital status, religion; cultural factors- beliefs, dietary norms, and customary practices among others. Situation analysis is followed by a process of thinking in which possible causes of action are examined, assessed and consequently one of them selected based on its relatively high value. This theory will help to explain the determining factors in health-seeking behaviour of women inmates. Are they cultural, biological, psychological etc?

### **Health Care Demand Model**

In the event of an illness, a patient is assumed to seek help from a health care system characterized by many providers. (Mwabu, Ainsworth and Nyamete, 1995:216). The patient or his relative is further assumed to choose the health care alternative that yields the maximum expected utility. Conditional on seeking treatment, the direct utility derived by individual (i) from treatment alternative (j) can be expressed as

$$U_{ij} = u_{ij} (h_{ij}, c_{ij})$$

Where  $u_{ij}$  is the direct utility that individual (i) expects from health care provider (j).

$h_{ij}$  is expected improvement in health status for individual (i) after receiving treatment from provider (j), and  $c_{ij}$  is the consumption of non health care goods, the amount of which depends on choice (j), because of the monetary and non-monetary costs of treatment from provider (j).

$$h_{ij} = h (x_i, z_{ij})$$

$$c_{ij} = y_i - e_{ij}$$

where  $x_i$  is a vector of observable socioeconomic attributes of individual (i), such as age and education.  $z_{ij}$  is a vector of medical and physical attributes faced by individual (i) in facility j, such as availability of drugs and medical equipment and sanitary conditions of



the facility.  $C_{ij}$  is the monetary value of non health care goods that individual (i) can consume after paying for medical care in facility j;  $y_i$  is annual income of household (i).  $e_{ij}$  is the value of resources that individual (i) devotes to medical care received from facility j. The level of  $e_{ij}$  is determined by such factors as the treatment fees, waiting time and access variables such as distance and travel time.

This model will help explain the factors that determine health-seeking behaviour of women inmates.

### **The Health Belief Model.**

The model was developed by psychologists Hochbaum, Rosenstock, Leventhal and Kegeles in 1958. It asserts that cognitive factors influence a patient's decision to change or modify a specific behaviour (Rosal et al, 2001). An individual will change a specific health-related behaviour if she or he believes that the behaviour makes him or her vulnerable to (or at risk for worsening) disease; changing the behaviour will decrease risk; there will be serious consequences if the behaviour is not modified; he or she is capable of taking action to change the behaviour; and the potential costs of taking action are outweighed by the benefits. In this case, the researcher hopes the health-seeking habits of inmates explain their state of health. Health care is in direct relationship with state of health of the inmates.

### **RESEARCH QUESTIONS**

From the literature review, it emerges that there are questions to be answered. The following research questions will guide the study:

1. With the Ministry of Health conceding that providing reproductive health is a great challenge and the obviously varied reproductive health services in provision across the country, what are the specific reproductive health interventions availed to women inmates?
2. Available literature shows that health-care facilities across the country do not offer uniform services. The quality is also far below the international standards. Factors such as distance from users, cost of treatment, health providers' attitude towards users and lack

of proper information on the part of users among others are major impediments in accessibility and utilization of reproductive health care. What is the quality and range of reproductive health services offered at Langa'ta Maximum Prison?

3. What are the viable ways of improving reproductive health-care in prisons?

## CHAPTER THREE: METHODS

### 3.1 Introduction

Any researcher faces some fundamental problems that must be solved before the project can be started. 'Whom shall I study? What shall I observe? When will observations be made? How will data be collected?' (Nachmias and Nachmias, 1996:99). This chapter involves the method that the study used in the data collection process, setting guidelines on whom to study, what to be observed, and when the observations will be made. This process is the research design. A research design is the 'blue print' that enables the investigator to come up with solutions to these problems and guides him or her in the various stages of the research (Nachmias and Nachmias, 1996:99). The chapter covers: site selection and description, unit of analysis, sampling procedure, data collection methods and data analysis.

### 3.2 Site Selection and Description

This is a case study of Lang'ata Maximum Women's Prison which is the largest women's prison in Kenya. It is also the only maximum women's prison in the country. It had a total population of 586 inmates comprising 311 convicted prisoners and 275 persons on remand by close of business on 11<sup>th</sup> February 2005 (Prison Headquarters, 2005:2). It is located on the Southern part of Nairobi about 15kilometres from the Central Business District.

### 3.3 Unit of analysis

The unit of analysis is the entity around which the variables of interest to the researcher vary (Singleton, 1998: 132). In this study, the unit of analysis was the prison itself. The observation units were individual women inmates, health care providers at the prison infirmary, and policy makers both at the prison headquarters and the Ministry of Health.

### 3.4 Sampling design

The researcher managed to access the prison after a long struggle to overcome great bureaucratic hurdles. Prisons are 'security zones' and access requires approval from the

authorities concerned which was a tedious and time consuming exercise. However, the researcher finally managed to conduct interviews as described below.

With the help of prison officers in identifying and calling out the inmates' names, 65 inmates were interviewed. Out of the 65 inmates, 35 were purposively selected and were either pregnant or with babies of not more than one year old. This helped the researcher gather information on pre-natal, delivery and post-natal care and child welfare services availed to the inmates. A snowball sampling method was used to recruit the other 30 inmates. Prison Officers referred at least 10 women, with the additional interviewees being referred by other women inmates whom they believed would be willing to participate in the process. At the end of each interview, the researcher requested the inmate to provide a referral to other women in prison. This group of inmates helped the researcher get information on other reproductive health concerns like STIs, HIV/AIDS, cancers of the breast and cervix, knowledge on reproductive health matters and so on.

To enhance the data collected in this assessment, the research team conducted in-depth interviews with key informants as a means of capturing experts' perspectives on reproductive health care at the facility.

### **3.5 Data collection instruments**

The study used interview schedules and structured observation. Relevant medical records, such as medical registers, were also reviewed.

#### **3.5.1 Interview schedule**

This tool was used to obtain information from key persons, that is, the health care providers at the service delivery point, like the nursing officer in charge – Lang'ata Maximum Women Prison, clinical officers and nurses. The other category was at policy level which got a separate interview guide. These included personnel responsible for health care administration and provision at the Ministry of Health. In this case, the number and wording of the questions was identical for all the respondents. The sequence in which the questions were asked was the same in every interview but allowance was given to informants to ask questions for clarity purposes.

The other category of respondents was the women inmates who got two different interview schedules purposely designed. There were two categories of respondents: 1- women inmates either pregnant or lactating, 2- other general women inmates who helped the researcher to gather information on other reproductive health concerns other than pre natal, delivery or post natal. Similarly, the researcher asked questions in the form and order prescribed in the interview schedules. The information the researcher hoped to get is covered under 3.7 (Expected Outcomes).

### **3.5.2 Structured observation**

The researcher observed and recorded the physical infrastructure, equipment, supplies and instruments relevant to the study.

### **3.5.3 Review of medical records**

With permission from the health care providers, the researcher reviewed medical records and got first hand information on the most common health reproductive health challenges and treatment procedures normally followed.

### **3.6 Data analysis**

This study was both qualitative and quantitative; hence collection and analysis took place at the same time. The field notes written in the course of gathering data were analyzed thematically. Based on themes developed, emerging patterns were elaborately described and classified. Thereafter, obtained information was summarized by the use of percentages, frequency distribution tables and cross tabulations.

### **3.7 Field Experiences**

The time frame for data collection in the field was close to two months. It was a long struggle to gain access to the prison. The researcher had to await approval to right of entry to the prison in the form of a letter allowing accessibility from the Commissioner of Prisons. The process of getting the paper work done itself took over three months. This was described as the only possible way of gaining admission since prisons were and are still considered "security zones". The main challenge was reaching the anticipated

sample target of 90 inmates. The target population was classified under three categories. These were general, pregnant and lactating inmates each targeting 30 women. The right sample size from the cohort of pregnant and lactating inmates was not realized. Out of possible 60 inmates, only 35 were interviewed since they were the only ones who were eligible at the time.

The researcher had wanted to personally administer the interview schedules to all the respondents but some opted to fill in the questions after insisting they were literate. Clarification of questions which were not clear to the interviewees was however done by the researcher. Some interview schedules were left behind especially for the key informants and were picked at an agreed date and time. It is important for the study to note that, in spite of setting pick up time, the researcher would make several trips and find schedules not completed or respondents not in office or off duty.

### **3.8 Expected outcomes**

Information derived from collected data in the field using interview schedule were reflected on;

#### **Health care providers' and planners' views on:**

**Reproductive health needs:** An analysis of health service needs within the community of women prisoners was provided by Health care providers and planners. Information indicated what equipment and/or services were lacking and needed to improve the quality of reproductive healthcare within the prison.

**Health care capacity:** Health care professionals provided their assessment on the capacity of prison health care facilities in terms of staffing, facilities and supplies for safe provision of specific interventions

**Cost assessment:** Health care providers and planners provided a breakdown of current and projected costs in running the health care facility. This information was used to illustrate the funds, manpower and/or equipment needed to bridge gaps and achieve the necessary carrying capacity.

**Health interventions:** Knowledge on effective, equitable, timely and appropriate health interventions for improvement of services in the women's prison was provided by the health professionals. This professional knowledge was complemented by intuitive suggestions from individuals and collectively on what ways would benefit the health services in the women's prison based on the unique needs of the community.

**Women incarcerated views on:**

**Availability and accessibility of services:** Information was acquired on the frequency and demand of health services by prisoners, and contrasted with the prisoners' accessibility to health services when needed. Particular focus was on their right of entry to a health facility when in need within the prison.

**Health providers' attitudes:** Women prisoners were interviewed on the attitude of health service providers. Information was gathered using indicators such as body language, politeness of health service provider, sensitivity of service provider to illness and/or pain of patient, and referral services to other health institutions if need arises.

**Knowledge assessment:** An assessment was conducted on the knowledge of reproductive health among prisoners. The process of assessment involved prisoner's knowledge of identification of disease, immediate response to reproductive health issues, knowledge of symptoms associated with reproductive illness, stigma associated with reproductive illness, and their sources of help when in need.

**Health perspectives:** Prisoners were interviewed on ways that they thought the Kenya government and/or health organizations could improve the quality of reproductive health services in the women's prison. In addition, individual and collective opinions of the prisoners were compiled to determine ways that reproductive health services could be improved at the prison by more efficient use of already existing resources.

Obtained information, statistically presented in the form of simple frequencies and cross tabulations, were used to summarize inmates' main reproductive health challenges and

preferred modes of availing treatment. It was the hope of the researcher that the findings of the study would positively influence reproductive health care provision for the vulnerable women inmates. The study recognized that women inmates have special reproductive roles, thus greater health needs than their counterparts, the men prisoners. Reproductive health care planning and administration should be tailored to specific women's needs in a prison set up.



## CHAPTER FOUR: SALIENT BACKGROUND CHARACTERISTICS OF THE RESPONDENTS

### 4.1 Background Information of the Respondents

A total of 65 respondents were interviewed; of these, n=30, were general inmates and were drawn from both remand and convicted sections. The other respondents, n=15, were pregnant inmates. Similarly, there was another category of inmates, n=20, who were lactating.

The study only managed to capture the targeted sample size from the category of general inmates but fell short of target from the categories of lactating and pregnant inmates. The number captured for pregnant and lactating inmates were the only ones available at the time the study was conducted. Otherwise many inmates had children above one year old. It is important to note that children above one year old do not usually attend well baby clinics and therefore interviewing their mothers would not have added value to the study.

The socio-economic parameters studied comprised respondents' age, marital status, religion and period of imprisonment.

#### 4.1.1 Age in years for the General Inmates

Table 1 shows the age distribution for the general inmates as follows:

**Table 1: Distribution of General Inmates by Age**

Age in years	Frequency	Percent
Up to 24	8	26.7
25-29	10	33.3
30-34	4	13.3
35-39	4	13.3
40-44	2	6.7
45 and above	2	6.7
<b>Total</b>	<b>30</b>	<b>100.0</b>

*Source: Field Data*

Of the total sample of general inmates interviewed aged 18-49 years, the age bracket 25-29 formed the modal class with n=10 (10 out of 30) representing 33.3% of the total. Closely following is the bracket of up to 24 years with 8 (26.7%) out of the total 30 general inmates. Another 13.3% or (4 out 30) were aged between 30-34 years and 35-39

years respectively, 6.7% were aged 40-44 and another 6.7% were aged 45 years and above. It is notable that age brackets 40-44 or (6.7%) and 45 and above (6.7%) have the least representation of 2 out the total 30 respectively. This may be interpreted to mean that the level of crime is highest among the women less than 30 years old. From the table it is arguably the trend that most women who commit crime are in their 20's which is a time associated with self discovery and a period of trying to achieve set ambitions in life.

#### 4.1.2 Distribution of Pregnant and Lactating inmates by their Age

**Table 2: Age Distribution of Pregnant and Lactating inmates**

Ages	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percentage
Up to 24	9	45.0%	10	66.7%	19	54.3%
25-29	7	35.0%	3	20.0%	10	28.6%
30-34	3	15.0%	1	6.7%	4	11.4%
35-39	1	5.0%	1	6.7%	2	5.7%
40-44	0	0	0	0	0	0
45 and above	0	0	0	0	0	0
<b>Total</b>	<b>20</b>	<b>100.0%</b>	<b>15</b>	<b>100.0%</b>	<b>35</b>	<b>100.0%</b>

*Source: Field Data*

Of the lactating inmates, age bracket of up to 24 years or 45.0% formed the modal class with n=9 (9 out of 20) while 35.0% (n=7) indicated that they were 25-29 years of age, 3 or 15.0% indicated age 30-34 and 1 or 5.0% was 35-39 years respectively. There was no lactating inmate from 40 -44 years and 45 years and above respectively.

From the cohort of pregnant inmates, the modal class was interestingly formed by the same age bracket as lactating mothers of up to 24 years with 10 out 15 showing a representation of 66.7%, while 20.0% (n=3) indicated 25-29years, 6.7% were aged 30-34 years and another 6.7% were 35-39 years. Ages 40-44 had zero representation as well as 45 years and above.

It is notable that the modal class for lactating and pregnant inmates is formed by the same age bracket of up to 24 years. The trend is the same with other age brackets of 30 – 34 years and 35 -39 with 1 inmate in both cohorts. Age brackets of 40-44 and 45 and above have zero representation. The level of crime is highest among women of up to 24 years as indicated from the lactating and pregnant inmates. However, general inmates' highest representation was between the age brackets of 25-29 years. From the findings of all cohorts, it is observable that the highest representation of inmates falls under 30 years of age. The reproductive age considered in this study was between 18-49years. This was then a representative sample hence the ability of the researcher to capture information regarding reproductive health related issues.

#### 4.1.3 Distribution of General inmates by Religion

Table 3 indicates that 83.3% of General inmates were Christians and only 16.7% were Muslims. From this distribution, it can be argued that Christians are more prone to committing crime than Muslims thus a higher representation.

**Table 3: Distribution of General Inmates by Religion**

	Frequency	Percent
Christian	25	83.3
Muslim	5	16.7
Total	30	100.0

Source: Field Data

#### 4.1.4 Distribution of Pregnant and Lactating Inmates by Religion

**Table 4: Distribution of Pregnant and Lactating Inmates by Religion**

Religion	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Christian	17	85.0	9	60.0	26	74.3
Muslim	2	10.0	2	13.3	4	11.4
No Response	1	5.0	4	26.7	5	14.3
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

Out of 20 lactating inmates, 17 or (85%) were Christians and only 2 (10%) were Muslims. In the category of pregnant women, 9 out of 15 (60%) were Christians while only 2 (13.3%) were Muslims. However, 5% (n=1) of lactating mothers and 26.7% (n=4) of pregnant inmates indicated neither of the two religions. There is an obvious higher representation of Christians than Muslims in both cohorts. From all sub-samples, Christians have a higher representation which could mean higher Christian population in the prison.

#### **4.2 Adequacy of health-related information for General Inmates**

As depicted on table 5 below, the general inmates rated health information given to them as follows: 43.3 % ( 13 out of 30) rated it as average. This was the modal rating. Another 13.3 % ( 4 out of 30) rated it as adequate, 10.0 % ( 3 out of 30) as very good and 10% as very inadequate. Another 20% (6 out of 20) of the general inmates considered the information inadequate. The level of health information given to the general inmates is far less adequate. The inmates in the adequate and very inadequate categories constitute 30% (n=9) of the total number of general inmates while those who think information is adequate and very adequate form 23.3% (n=7) of the general inmates. However, 43.3% (n=13) felt information given to them was average. The information given to the inmates in terms of amount and quality is less than adequate. This study considers average classification as not enough and not too good, therefore the prison population is not well informed on medical issues. In the literature review residents of informal settlements and inmates in general were said to be poorly informed on medical issues. In fact even the general population in Kenya is poorly informed on health related issues and when it is done at the health care facilities, it is usually hurried and brief.

**Table 5: Adequacy of health-related information for General Inmates**

	Frequency	Percent
Very adequate	3	10.0
Adequate	4	13.3
Average	13	43.3
Inadequate	6	20.0
Very inadequate	3	10.0
No Response	1	3.3
<b>Total</b>	<b>30</b>	<b>100.0</b>

Source: Field Data

**Table 6: Adequacy of health-related information given to Pregnant and Lactating inmates**

	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very good	0	0	1	6.7	1	2.9
Good	0	0	1	6.7	1	2.9
Average	4	20.0	6	40.0	10	28.6
Inadequate	14	70.0	7	46.7	21	60.0
Very Inadequate	1	5.0	0	0	1	2.9
No Response	1	5.0	0	0	1	2.9
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

From table 6 above, 4 out of 20 (20%) lactating inmates rated the information provided to them as average, 14 (70%) as inadequate and 1 (5%) as very inadequate. In the category of pregnant inmates, 2 out of 15 (13.4%) rated the information as good or very good, 7 out of 15 (46.7%) as inadequate, 6 (40.0%) as average. Majority of inmates in both cohorts felt that information given to them was inadequate, 70% among lactating inmates and 46.7 % among pregnant inmates. From the cohort of lactating inmates, it is clear that health related information provided is scanty which is a scenario confirmed by the Penal Reform International report (PRI, 1993:28) which says that the prison population is poorly informed about health care, infectious diseases and STIs. It could be referred to as an 'ignorant society.' It is equally in agreement with Ngacha, 1998:12, who

says that health information relayed to the general population outside the prison set up is poor. No wonder, as Ngacha highlights in the literature review, 90% of the women admitted to Kenyatta National Hospital with cancer of the cervix have had no regular gynecological screening. Most women at Kenyatta National Hospital present with advanced disease and have never heard of Pap smear examinations.

On the contrary, 8 (53.4%) of the pregnant inmates rated information given to them as average, good and very good. It is important to note that these inmates visit the ante-natal clinics for check up every month at the early stages of pregnancy and every week from the eighth month of the pregnancy. In such forums, observations on the mother and fetus are taken and necessary advice is accorded. This explains the rating of health information from this group. However, 46.7% of pregnant inmates rated information as inadequate which could mean that there are some inmates who despite having the ante-natal clinics, felt comprehensive health information was not given.

**Table 7: Assessment of the range of reproductive health services availed to General Inmates**

	Frequency	Percent
Very adequate	1	3.3
Adequate	6	20.0
Average	13	43.3
Inadequate	8	26.7
No Response	2	6.7
<b>Total</b>	<b>30</b>	<b>100.0</b>

Source: Field Data

As depicted in table 7, respondents rated the range of health services availed to them as follows: - 43.3% (n=13) which forms the modal class rated them as average, 26.7% (n=8) of the respondents rated them as inadequate, while 20.0 % ( n=6) of the inmates rated them as adequate and only 3.3% (n=1) rated them as very adequate. However n=2 (6.7) gave a no response. Reproductive health services that the study was looking for are like health care related to pregnancy and child birth, STDs and AIDs, cancers of the cervix and breasts, and the woman's total well being through out her reproductive life cycle. The above illustration from table 7 is a clear indication of unavailable services to the women inmates. From the study's problem statement, a reproductive health needs assessment

carried out in eight selected districts of Kenya, it was conceded that providing reproductive health services to rural areas especially is a great challenge (APHRC & PC, 2001:12). This scenario can only be worse for reproductive health care provision in Kenya's main maximum women's prison with a 70% representation of respondents registering average and inadequate.

**Table 8: Distribution of lactating inmates by place of most recent delivery**

		Delivered at					Total
		Home	Pumwani	Kenyatta	Langata Ward 2	No response	
<b>Lactating inmates</b>	Count	1	6	9	1	3	20
	%	5.0%	30.0%	45.0%	5.0%	15.0%	100%
<b>Total</b>	Count	1	6	6	1	3	20
	%	5.0%	30.0%	45.0%	5.0%	15.0%	100%

*Source: Field Data*

A total of 9 respondents gave birth at Kenyatta National Hospital while at prison, one delivered at Lang'ata ward 2 and others had given birth prior to joining the prison community in Pumwani and at home respectively. It is important to note that delivery is not supposed to be at the prison wards. The 5% representation (Lang'ata Ward 2) is a case of late referral and/or slow response to a transfer request to Kenyatta National Hospital. This situation confirms the literature review that pregnant inmates are normally referred to government hospitals as there are no delivery kits in prison health centres. It is therefore important to view the pregnant prisoners as a vulnerable group, and the need for provision of necessary resources to the health centres cannot be over emphasized.

## Pap smear Tests while in Prison

**Table 9: Distribution of General inmates by whether they ever had a Pap Smear Test while in Prison**

Pap Smear Test	Frequency	Percent
Yes	4	13.3
No	25	83.3
No Response	1	3.3
<b>Total</b>	<b>30</b>	<b>100.0</b>

*Source: Field Data*

Table 9 indicates that 83.3% of the respondents had never had Pap smear test while they were in the prison, 13.3% (n=4) had ever had the test, one had no idea what Pap Smear Tests were. Pap Smear Tests are periodic examinations of a woman's mucosal substance to determine presence or lack of cells that lead to cervical cancer. The service is not provided within the prison but referred to Kenyatta National Hospital when symptoms of a disease appear. In the event of discovering cervical cancer or features alluding to the presence of it in a patient, a referral to Kenyatta National Hospital is then made for radio therapy and further management. However, this is the only government facility in the country with this service (radio therapy), and its accessibility to the inmates convenience is doubtful.

**Table 10: Distribution of General Inmates in terms of Breast Examination**

	Frequency	Percent
Examined while in Prison	1	3.3
Not Examined	28	93.3
No Response	1	3.3
<b>Total</b>	<b>30</b>	<b>100.0</b>

*Source: Field Data*

An Overwhelming 93.3% (n=28) had never had breast examination while they were at the facility and only 3.3% (n=1) gave a yes response. This widespread lack of observation may be interpreted to mean unavailability of preventive intervention strategies for reproductive health such as breast cancers. On the other hand, one respondent underwent breast examination though the study was unable to establish who the examiner was. In this case, it could have been a fellow inmate or a health care giver.



## 4.2. Utilization of Reproductive Health Services

**Table 11: Number of times the inmates attended the health care facility in the last nine months**

Months For the year 2005	Number of Times Inmates Visited the Health Care Facility in the Last Nine Months							Total
		1	2	3	4	5	Never visited	
January	Count	6	5	2	1	2	14	30
	%	20.0	16.7	6.7	3.3	6.7	46.7	100
February	Count	2	4	1	2	1	20	30
	%	6.7	13.3	3.3	6.7	3.3	66.7	100.0
March	Count	1	0	4	1	3	19	30
	%	3.3		13.3	3.3	10.0	63.3	100.0
April	Count	3	2	5	1	3	16	30
	%	10.0	6.7	16.7	3.3	10.0	53.3	100
May	Count	4	1	2	1	2	20	30
	%	13.3	3.3	6.7	3.3	6.7	66.7	100.0
June	Count	4	3	2	2	2	17	30
	%	13.3	10.0	6.7	6.7	6.7	56.7	100.0
July	Count	2	5	1	3	1	18	30
	%	6.7	16.7	3.3	10.0	3.3	60.0	100.0
August	Count	4	1	2	0	3	20	30
	%	13.3	3.3	6.7	0		66.7	100.0
September	Count	4	4	3	0	5	14	30
	%	13.3	13.3	10.0	0	16.7	46.7	100.0

Source: Field Data

Table 11 shows the utilization of the health facility by the inmates on a monthly basis. In January, for example, 20.0% attended the health facility once, 16.7% attended twice, while 6.7% attended three and another 6.7% attended five times with only 3.3% attending once. Among the respondents interviewed, the months of February, May and August had the highest percentage/count 66.7% of those who never visited the health clinic. This scenario does not seem to explain any trend and cannot indicate factors that determine demand for the service. From the researcher's observation during the time of the data collection, at least half of the respondents flocked the clinic to receive jabs for different ailments not taking into account the many other inmates who were not part of the sample selected but kept waiting for the clinic doors to open. The demand for health care is higher and sometimes the staff gets overwhelmed.

**Table 12: Provision of Antenatal/ Postnatal care for the pregnant and lactating inmates by the health care givers from the prison clinic.**

	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Consulted someone	20	100.0	12	80.0	32	91.4
Did not consult someone	0	0	1	6.7	1	2.9
No response	0	0	2	13.3	2	5.7
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

*Source: Field Data*

Table 12 shows that all the 20 lactating inmates had consulted the prison health care providers for their ante-natal and post-natal needs. Similarly, 12 (80%) out of 15 pregnant inmates had equally been examined by the clinic staff for ante-natal services. Specifically the staffs were clinical officers and nurses. This was corroborated by key informants who pointed out that antenatal clinics are held every week by prison health care givers at the prison clinic to capture new entrants. It was done in the one room 'all purpose clinics.' Otherwise the trend/norm pregnant is that pregnant inmates pay antenatal visits at the health clinic within the prison once a month unless there is a complication before the appointment date.

However, a full fledged clinic had been put up comprising of the laboratory, ante-natal room, doctors room, VCT site and pharmacy at the time of the study. This was an expansion programme and initiative of the Kenyan Government in collaboration with USAID. The expectation of the prison staff, medical and non medical was that the staff there in would shift their operational base from the one room congested clinic to the new facility. Nevertheless, it was not operational yet since its use had not been authorized by the donor/Government.

### 4.3.1 Post Natal Visits

**Table 13: Post Delivery Check up after leaving hospital for lactating inmates**

Post delivery	Frequency	Percent
Yes	17	85.0
No	1	5.0
No Response	2	10.0
<b>Total</b>	<b>20</b>	<b>100.0</b>

*Source: Field Data*

Out of 20 lactating inmates 17(85%) had had post delivery check up at least once a month. This trend of post natal visits seem to match with the recommended post natal standards for sustained and lactation period-free of complications. A pregnant woman is required to visit ante-natal clinics at least once a month up to thirty six weeks and every once a week up to delivery. Similarly, post –natal clinic should take place six weeks after delivery. This qualifies the researcher’s earlier observation that the standards for post-natal check up within the prison set up are in rhyme with international recommended standards.

### 4.3.2 Child Health Care after delivery

**Table 14: Baby clinic after delivery by a health care provider**

Check on Baby	Frequency	Percent
Yes	13	65.0%
No	4	20.0%
No Response	3	15.0%
<b>Total</b>	<b>20</b>	<b>100.0%</b>

*Source: Field Data*

The study sought to find out if babies go through the recommended clinics and immunization processes after delivery. The table indicates the following; Out of 20 respondents, 13 with a representation of 65% confirmed they had sought medical attention, 4 (20%) indicated they had not sought any medical attention and 3 did not respond. Child well baby clinics are mandatory with an intention to reduce neo-natal, post-natal and subsequently child mortality rates. The rates indicated above are therefore a bit disturbing since the yes response should have been at least 80%. However the study also considered the time an inmate joined the prison. There were those who formed the sub-sample and their stay was less than two months but their children were above six

months and less than nine months old. Ordinarily, immunizations go up to six months with a break till the last jab at nine months.

### 4.3.3 Quality of Health Care

**Table 15: Quality of service in provision of reproductive health services provided at the facility as indicated by the General Inmates**

Quality of Service	Frequency	Percent
Very good	3	10.0
Good	3	10.0
Average	17	56.7
Bad	4	13.3
Very Bad	2	6.7
No Response	1	3.3
<b>Total</b>	<b>30</b>	<b>100.0</b>

Source: Field Data

The general inmates were requested to rate the quality of the reproductive health services provided to them in the facility where n=17( 56.7%) rated it as average, 10.0% indicated very good and another 10.0% indicated good while 13.3% rated it bad, 6.7% rated the service very bad and 3.3% indicated a no response. From the inmates' perspective, 77.7% indicated average, good and very good. A total of 20% indicated bad, and very bad. The study views most of the respondents as those who visit public health facilities while out of prison. It is important to note that "the well of to do" in our society do not stay behind bars for long since they usually afford fines preferred against them. In this case the respondents were seen to compare the quality of health care in the prison with the public system in Kenya and therefore many gave an average response here seen as satisfying quality.

**Table 16: Quality of reproductive health Services as reported by pregnant and lactating inmates**

Quality of Service	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very good	0	0	1	6.7	1	2.9
Good	1	5.0	1	6.7	2	5.7

Average	15	75.0	7	46.7	22	62.9
Inadequate	2	10.0	2	13.3	4	11.4
Very bad	2	10.0	3	20.0	5	14.3
No Response	0	0	1	6.7	1	2.9
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

The study sought to seek views of the pregnant inmates and those with babies on quality of reproductive health services availed to them at the prison and the following were the responses. A total of 15 (75%) lactating inmates rated the services as average. Similarly, the highest representation in the cohort of pregnant inmates is highest at the average category with a representation of 46.7%. The modal class is therefore in the average response group. A representation of 20% is indicated as inadequate and very bad among lactating inmates.

From the two cohorts, 71.5% rated the quality of reproductive health services as average to very good while 88.6% saw it as average to very bad. However, 62.9% of the total saw it as average. This then may indicate that most of the inmates found the services standard which may be seen not to agree with an earlier report quoted in the literature review from the Kenya Human Rights Commission stating that prisons health care provision is in a sorry state. The Langa'ta case study from the inmates' point of view dictates otherwise.

#### 4.3.4 Health Providers' Attitude towards the patients

The researcher sought to capture the attitude of the health care providers towards the patients/inmates by asking the respondents if they ever encountered hostile care givers and if the response was positive, the respondents were asked to give details.

**Table 17: Rating of the health provider's attitude to patients by lactating and pregnant inmates**

	Lactating inmates		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very good	1	5.0	0	0	1	2.9
Good	2	10.0	7	46.7	9	25.7

Average	13	65.0	4	26.7	17	48.6
Bad	2	10.0	0	0	2	5.7
Very bad	2	10.0	4	26.7	6	17.1
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

From the group of lactating inmates, 13(65%) rated the attitude as average, 20% indicated bad and very bad and n=1(5%) rating it as very good. In the cohort of pregnant inmates, n=7(46.7%) indicated the attitude as good, n=4 (26.7%) as average and very bad respectively. The modal class is formed by the category of average in the cohort of lactating inmates and the good response forms the modal class in the group of pregnant inmates. It is important to note that at the point of administering this question, the respondents were a bit hesitant and were afraid of giving a negative response for fear of victimization. However, the above illustration does not really allude to mistreatment of patients by the health care providers. The study can therefore state that the attitude towards patients ranges from average to good.

**Table 18: Rating of the health providers' attitude to patients by General Inmates**

	Frequency	Percent
Very good	7	23.3
Good	5	16.7
Average	13	43.3
Bad	2	6.7
No Response	3	10.0
<b>Total</b>	<b>30</b>	<b>100.0</b>

Source: Field Data

The general inmates were requested to rate the attitude of the health providers towards them. A total of 13 inmates (43.3%) rated the attitude of the health providers as average, n=7(23.3%) rated it as very good, while n=5(16.7%) rated it as good, with only 6.7% rating it as bad. A non response was given by n=3(10%) of the respondents. From the earlier prediction in the illustration by pregnant and lactating inmates, the attitude towards the patients in the prison is fairly good with 83.0% recording average, good and very good. This is further supported by the key informants input on their attitude towards the patients which was rated as very good by all the respondents. From the researcher's observation during the period of interviews and regular visits, the health care givers are

indeed friendly to the inmates. They seemed to understand that inmates have other psychological problems and illnesses as a result of imprisonment. These problems range from family disintegration, community stigmatization among others.

From the researcher’s point of observation, the numbers of clients’ seeking a service are far too many to be handled by the care-giver on duty at any one time. In a span of 10 minutes, 30 inmates had been treated. The confidentiality protocol was not practical. The clinic was too busy with little time for each patient and the researcher could only conclude that the prisoners’ complaints were not well attended to. Similarly, there were no indications of record writing for patients within the time. The researcher through observation did not get to see piles of files that would match the number of clients who sought treatment. Like wise, it was evidently clear that there was no computerization in place for medical records. This scenario is informative and the study can conclude that health care provision within the prison does not in any way match the expected national or international standards.

This situation, confirms the findings of Kenya Human Rights Commission, which says that dispensaries in a prison set up are characterized by long queues with some incarcerates too weak to stand (KHRC, 2002: 26). To describe it aptly, health delivery in Lang’ata Women’s Prison is like the emergency room. Everything is noisy and done in a hurry compromising the health standards at the prison.

**4.3.5 Hostile Health Care Givers**

Inmates were asked if they have ever encountered hostile care givers in the course of their treatment at the prison. Table 19 below captures the responses.

**Table 19: Lactating and Pregnant Inmates encounter with Hostile Health Care Givers**

Hostility of Health care giver	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	12	60.0	2	13.3	14	40.0
No	8	40.0	11	73.3	19	54.3

No response	0	0	2	13.3	2	5.7
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

A total of 12(60%) of lactating inmates said they had encountered hostile care givers, while 8(40%) of them said they had not. The modal class here is formed by the yes responses. From the cohort of pregnant inmates, 11(73.3%) had not encountered hostile care givers while 2(13.3%) gave a yes response. Out of a total of 35 inmates from both cohorts, 14 indicated yes while 19 indicated no. There were 2 who did not respond.

Among the reasons given by the inmates to explain hostility were; lack of privacy, rude language and failure to listen attentively to the patients. The above illustration does not give a fine conclusion of whether health care givers are hostile or not because the yes and no responses almost tally. However, the majority still indicated no hostility and the study can only say that care givers are not really hostile. Lack of privacy and failure to listen keenly is not hostility but are operational problems.

#### 4.3.6 Special Diet when Pregnant and /or soon after birth

The lactating and pregnant inmates were asked if they ever received a special meal after birth. The responses are captured here below.

**Table 20: Special meal when pregnant and/or soon after birth**

Special Meals	Lactating		Pregnant		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	3	15.0	1	6.7	4	11.4
No	16	80.0	13	86.7	29	82.9
No Response	1	5.0	1	6.7	2	5.7
<b>Total</b>	<b>20</b>	<b>100.0</b>	<b>15</b>	<b>100.0</b>	<b>35</b>	<b>100.0</b>

Source: Field Data

From the cohort of lactating inmates, n=16(80%) inmates said they did not receive any special meal either before or after birth. Similarly, 13 (86.7%) pregnant inmates confirmed that they did not receive any special meal. The modal class was formed by the inmates who responded no. From the researcher's point of observation, the illustration above seems to agree on what was served at those times when the study took place. The



vulnerable group of inmates here considered being those pregnant as well as those in the maternity wards after having given birth, were on the same diet as those in the general prison cubicles. The meal then comprised of white 'ugali' and scanty green vegetables with a lot of clear/colorless soup. This corroborates the evidence in the literature whereby pregnant inmates were said to receive no special diet, and quality of food provided was poor and lacked the nutritional value. In fact, from the researcher's point of view, pregnant and lactating mothers are constantly exposed to deteriorating health conditions.

#### 4.3.7 Sexual Assault in the facility

The general inmates were asked if they had ever heard of sexual cases as long as they had been in prison. Sexual assault is here defined as any sexual intercourse with an inmate without the inmates consent. The findings are indicated below.

**Table 21: General inmate's indication of Sexual Assault within the prison walls**

No of times one has heard of sexual assault	Frequency	Percent
2 times	3	10.0
Not heard at all	27	90.0
<b>Total</b>	<b>30</b>	<b>100.0</b>

*Source: Field Data*

A total of 27(90.0%) indicated they had never heard of any sexual assault within the prison. However n=3 (10.0%) indicated they had ever heard sexual assault within the institution. Upon probing for details of when, where and by whom, the inmates confirmed that they were actually allegations. However, key informants alluded to sexual assault as well consensual relationships at the police/court cells when inmates are taken to court for case mentions, hearing and judgment. From the key informants input, there is actually no sexual abuse within the prison boundaries and therefore the study can confidently conclude that there is no sexual assault within the prison set up.

## Key Informants

A total of 9 key informants were interviewed in this study. A brief description of their occupation is given below.

### Key informant

#### 1. Occupation

	Frequency	Percent
Public Health Technician	1	11.1
Nurse	3	33.3
Clinical Officer	1	11.1
Nutritionist	1	11.1
Ministry Officers	3	33.3
<b>Total</b>	<b>9</b>	<b>100.0</b>

*Source: Field Data*

Out of 9 key informants, 3(33.3%) were nurses, another 3(33.3%) were officials from Ministries of Health and Home Affairs, while the others were public health technician, clinical officer and nutritionist respectively. It is quite evident that there was no doctor interviewed. This is because doctors make few/occasional visits to the facility within the prison. Their times of visits to the prison are unpredictable and more often than not referrals are made to Kenyatta National Hospital, for specialized treatment. The key informants interviewed felt that getting to interview a doctor may actually take an indefinite time due to their irregular visits.

From the above illustration, the study may firmly say that inmates do not receive specialized treatment and very complicated cases are handled by the nurses. This is because the prison department does not have its own doctors but relies on the ministry of health to second doctors to the prison health clinics. The health care professionals in the women's prisons, confronted with this reality, therefore manage the problems they face only to their best of abilities which is obviously limiting in terms of effective and accurate diagnosis and management. This situation as had been highlighted earlier confirms that the system has structural problems and prisoners do not receive relevant and appropriate treatment.

## CHAPTER FIVE: RESEARCH FINDINGS

The purpose of this study was to investigate what forms of reproductive health-care interventions are offered to women inmates at Lang'ata Maximum Women's Prison.

The discussion on this chapter is devoted to answering the three research questions posed on page 21 above.

### **5.1 Reproductive health interventions offered in the prison (Research Question 1)**

Reproductive health is a comprehensive component of health in general which encompasses safe motherhood, adolescent health, health information or all those aspects of health concerned with the process of reproduction and especially regarding mother and child. Such are fertility/infertility, prenatal care, delivery, post-natal care, child health, abortion, adolescent health and health information.

The study sought to establish the specific interventions offered to women inmates at Lang'ta Maximun Women's Prison. A few reproductive health interventions are offered within the prison set-up. These are pre-natal, post-natal, expanded program on immunization, treatment of STD's including HIV, and reproductive health information. Pre-natal in this case is defined as the pre-care accorded to a pregnant woman and post natal as care that is given to a woman after giving birth. Expanded program on immunization comprises of standard organized management of babies mostly up to nine months of age. HIV/AIDS involves administration of ARV drugs which are among the few drugs that inmates are allowed to carry to their cubicles. This is basically because the drugs are taken at specific times and at such times the clinic may not be accessible. However, the state of services as availed to women prisoners still does not match the international/national standards as illustrated below.

The following report illustrates the struggle of many incarcerated women to secure adequate health care.

*On the night of April 20th I started spotting (bleeding). I told the guard and she said medical care person was not in at that time of night and there was nothing she could do. As the night went on the bleeding got worse and so did my stomachache. I didn't sleep at all that night and when the guard passed by me I was crying and I told her the bleeding was getting worse and that I couldn't stand the stomach cramps I was having.."* [The following day Annette (not her real name) continued to bleed and in the afternoon she

*collapsed and was taken to hospital and immediately taken to theatre.]. "...I still to this day have dreams about what happened. I will never forget it. It was the worst thing I have ever experienced. If they would have only helped me when I first asked all this would not have happened nor would I have had to lose my baby. It was an awful experience and one that will be with me forever. I thank God everyday that I'm alive and I pray this never happens to anyone else."*

*(Annette, talking of her experience in Langa'ta Maximum Women's Prison in 2004).*

However, this case does not necessarily mean that medical care is at its worst. According to the findings as illustrated previously, the majority of the women feel that the services availed are average. For the purpose of this study, average is taken to mean availability and appreciated effort recognizable by the inmates and according to their own perceptions.

Table 12 on page 37 indicates that there is adequate provision of ante and post-natal care to the inmates. At least 80% of the inmates (refer to table 12) had consulted someone. Key informants put it clearly that they hold an antenatal clinic every week which is indeed an adequate service.

Nevertheless as earlier put, the majority of women who usually stay long in prisons are from socially and economically deprived backgrounds since the well to do inmates do somehow find their way out. The health care they ordinarily manage to access while outside the prison is government sponsored which is characterized by long queues, user fees, lack of drugs and referrals to distant hospitals in case of a complication. A referral in this case demands that transport as a matter of necessity must be paid for. In contrast to the prison set up, factors like user fees and transport costs are not met by the patient, in this case the woman inmate.

Women inmates said that STDs, HIV/AIDs, diarrhoea, skin and respiratory diseases are the most common diseases within the prison. This was in agreement with the providers who felt that HIV/AIDs, STDs, diarrhoea and skin diseases were the most serious health risks of the women inmates. The study notes that health needs of the inmates are not wholly met.

## **5.2 Quality and range of reproductive health services within Langa'ta Women's Prison (Research Question 2)**

The provision for gynecological services for women in prison was inadequate. Female specific services like pap smears and mammograms were not offered. They were normally referred to Kenyatta National Hospital and this was only when the symptoms of a disease appear. This led to poor quality treatment causing physical deterioration of prisoners with chronic and degenerative diseases like cancer. Similarly, contagious and infectious diseases were rampant among the prison population. This is one of the major health challenges the government has to face. This was attributed to high population levels and poor ventilation within the prison wards.

From table 7 on page 33, most general inmates (43.3%) indicated that the range of reproductive health services availed to them at the prison is average and 26.7% indicated inadequate. As explained earlier, reproductive health services within the prison are not comprehensive. A wide range of other health interventions to serve the woman in totality need to be designed and implemented within the prison walls. This is further illustrated in tables 9 and 10, where general inmates were asked whether they ever had Pap Smear or breast examination. A total of 25 (83.3%) and 28(93.3%) general inmates indicated they had not had the services of Pap smear and breast examination respectively. Inadequate provision of reproductive health services cannot therefore be emphasized.

From the observation checklist, it was evident that facilities like blood pressure machines, were available but not in a working condition. A blood pressure machine is a critical component in the diagnosis, treatment and management of any ailment. Lack of this machine implies that decisions taken on the patients are not entirely accurate and a patient may be treated for the wrong thing.

However, the study confirmed availability of equipments like baby weighing scales, stethoscopes, examination table, immunization forms; all working and in good condition.

At the time of the study, there were no provisions for isolation blocks to cater for those suffering from infectious diseases. This was gathered through the interview with the key informants. Ironically, there were neither guidelines nor policies on segregating those

suffering from HIV/AIDS or contagious diseases. Sick inmates were mixed up with the rest, resulting in high infection rates and sometimes deaths.

The key informants informed the study that there is no medical officer based at the prison and their visits were unpredictable. In standard practice, Medical Officers are supposed to diagnose and prescribe drugs for patients. Lack of Medical Officers implies that patients are treated by nurses who the researcher found on duty through out the study period. Nurses are best in managing patients by their mode of training but not making critical decisions on treatment course. Quality of provision of health care is thus questionable at the prison.

There is absence of informed knowledge on health by which women can learn of the realities surrounding their health conditions. From table 6 above (page 32) 70% of lactating inmates and 46.7% of pregnant inmates rated information given to them as inadequate. This is a clear indication of scanty health information given to the inmates.

Utilization of health care within the prison does not seem to have any trend as depicted on Table 11 above. The study was not able to establish the determinants behind seeking health care within a prison set up unlike the community beyond prison walls. From the literature review factors like user fees, distance to the health facilities, cultural and social beliefs influenced health seeking habits in the communities. However, there is great demand for health care within the prison as was observed within the study period.

### **5.2.1 Gaps in delivery of reproductive health-care**

#### **a) Health-Care System**

All key informants confirmed that female inmates have more health care demands and have far more medical problems as one stated thus, “You see an inmate on sick call and she has eight or ten complaints.” The key informants indicated that the health care system is highly overburdened and its population is very needy. This was concurred by the researcher’s findings through an interview with the policy makers at the ministry of health. Correctly put ‘women prisoners go to doctors two and half times more than men.’ The policy makers alluded to the point that women have problems that men do not have – such as depression and gynecological problems. The key informants and policy makers as

well informed the study that the women's institution is modeled after the male prisons but the latter require far fewer resources and less medical attention to the inmates.

Failure to refer seriously ill inmates for treatment and delays in treatment are common at the prison; and when treatment is provided, it usually takes the form of dispensing pain killers for any ailments. Sadly put by a key informant is that inmates suffering from treatable diseases such as T.B. and late term miscarriages have little or no medical attention, sometimes resulting in death or permanent medical injury. This delay was attributed to lack of a prison ambulance. The prison shares an ambulance with Otiende Health Centre and is usually unavailable when required. Similarly, duty officers take too long to call for one. It is sometimes a situation of 'too little too late.' Communication hindrances were also attributed to the delays. There were no telephone extensions in the health clinics or within the reach of the care givers. Making an emergency call is a tedious process as one has to call the switchboard and sometimes the emergency of the condition is underestimated. This confirms Kenya Human Rights Commission report that tedious bureaucratic hurdles and procedures that must be followed at every juncture first aggravate the already bad health situation in Kenyan prisons.

Drug availability is still an impediment to effective provision of care. Sometimes, stocks run out and this compromises the health of the inmates. However, notable progress since the change of government from KANU to NARC in 2003 is that Kenya Medical Supplies Agency disburses drugs to the facility faster than before. Previously, there were long bureaucratic systems to be followed and drugs could run out for a considerable period of time.

**(b) Inadequate availability of qualified personnel**

There are too few staff to meet physical needs of the prison population. This was attributed to the increasing prison population against a non growing health staff. The policy makers at the Ministry of health confirmed that there is not (an) equal amount of staffing in women prisons. This further concurs with the (PRI) report that there are no incentives to attract doctors to work in prisons, since the government dedicates fewer health resources to prisons. Basic treatment of prisoners requires that every health facility

should have at least one qualified doctor. Section 29(2) of the Prisons Act (page 15) provides that there shall be a Medical Officer stationed in or responsible for every prison, and shall cause all prisoners in a prison to be medically examined at such times as shall be prescribed. It further states that the medical officer shall be responsible for the health of all prisoners in a prison. The key informants informed the study that there are no medical officers based at the prison and their visits were unpredictable. This indeed contravenes the documented policy on health provision within the prison.

### **(c) Inadequate physical facilities**

Available hospital beds were not adequate. A visit to the prison's maternity ward revealed a scenario of an 'overstretched facility.' At least 3 women and their babies were sleeping on thin mattresses on the floor. However, commendable were the standards of cleanliness of both the ward and the patients.

Sanitation and water facilities were not adequate for the population. This compromises the hygiene standards and mostly leads to diarrhoea and contagious skin infections beating the noble NARC government initiative of prison reforms.

Facilities like transport in case of a referral to a higher health care facility like Kenyatta National Hospital and lack of a laboratory on site are other critical inputs in health provision. Some tests are vital before any medication is administered and lack of testing facilities implies that proper investigations are not carried. This means then that decisions about operative interventions are not always accurate.

Providers noted that lack of facilities like delivery kits and screening facilities was a major barrier to performing and providing screening services (pelvic exams and pap smears). Providers also cited shortage of provider-time as another impediment to quality of health care. The clinic opens its doors to the inmates at specific hours in any day. The number of providers on duty at any one time is inadequate to handle the many clients in the queue.



#### **(d) Inadequate budget allocations**

Health is just one of the needs of a prison. Others are like food, clothing, beddings, staff needs like housing and salaries. However, according to the findings from the Ministry of Health, budgetary provisions are far below a realistic allocation. At the time of the study, the policy-maker interviewed indicated that the health budget for the year 2003/2004 financial year was a paltry 2.2million shillings for all prisons within the country which is undoubtedly quite insufficient. It is a situation of 'a make do with what is available.' No wonder, then, health services remain below minimal acceptable standards in prisons.

### **5.3 Viable Ways of Improving Reproductive Health Care Service Provision in Langa'ta Maximum Women's Prison (Research Question 3)**

#### **a) Establish a Comprehensive Female Health Care System**

Although fewer in absolute numbers, compared to their male counterparts, female inmates are growing faster in numbers, have more complex health problems, and utilize the health care system more. This was an emphasis by a Policy Maker based at the Ministry of Health. To provide 'equivalence of care' for prisoners, there is need to implement full electronic clinical records in prisons and ensure staff has access to resources on the internet. Besides, each prisoner should have a confidential clinical health record. This will ensure effective health care to prisoners and accountability in drug administration among others as there will be proper checks and control in place. The clinic should also be open for long hours to cater for the high demand of medical attention by the inmates.

Patient observations and treatment should be conducted in private. At the time of the study, inmates were treated in one undemarcated room which was characterized by one long queue which was overflowing to the outside. There was no privacy accorded to any sick inmate.

Women inmates should be offered constant comprehensive medical education on reproductive issues. These are like HIV/AIDs, breast care, STIs etc. Medical education should 'begin-but not end' with women incarcerated for less serious offences since they

will be released into the community the quickest. Interventions targeting Aids risk behaviour among women in jail world ultimately reduce Aids in the general community. Translation of some materials into vernacular languages should also be given some consideration.

Maternity needs should be addressed thoroughly. This includes putting up a full-fledged maternity ward and prison clinic equipped with delivery kits as a matter of necessity. Systematic counseling services and appropriate follow ups for inmates should be put in place. Specialized baby units and 'we'll woman clinics' should be a consideration. This will ensure timely management decisions on specific cases are made in and on time. Pregnant and nursing mothers should be provided foods that are both highly nutritious and well balanced. Other unwell/sick prisoners should be provided with special diets recommended to them by doctors. In a nut shell, health and development needs of children in prison with their mothers should be addressed in a systematic manner.

Prison authorities should permit toiletries such as medicated soaps and oils to contain preventable and manageable health conditions. These could take many forms, among them; being a procurement necessity by the prison

Periodic examinations on inmates such as pap smears and breast examinations should be initiated in the prison clinic. Patients are referred to KNH only when symptoms appear and by then the disease has already spread to irreversible levels. If regular and periodic exams are introduced and carried out within the prison, many lives would be saved since early and timely interventions would be put in place.

**b)Develop programmes of sanitary education including being open to NGOs and well wishers.**

Lang'ata Womens Prison in particular has been quite open to well-wishers, corporate world and NGOs. They have been receiving donations of e.g. sanitary needs, children's clothing etc. However, the prison population is way above and the donations are not sufficient to the inmates. Stringent measures like having long term partnerships with manufactures of such essentials should be put in place to fill the gap.

**c) Encourage private/ mobile clinics.**

These should step in and reduce the hassles of referrals to the government facilities like Kenyatta National Hospital which are already overstretched. This vulnerable group of women would then be assured of adequate health treatment as well as ensure equality of access to health care just like the community beyond the prisons.

**d) Increase allowances of Medical staff there in**

This would guarantee professional availability thus ensuring timely treatment and in the long run reduce operational costs. A holistic approach should be adopted which involves paramedics and social welfare staff being deployed to the prisons.

**e) Non-custodial services for pregnant mothers.**

This though may be controversial; a pregnant mother should be given a sentence that is beyond confinements. It is based on the assumption that a pregnant woman would be better off outside the prison set up.

**f) Finances**

Adequate finances should be made available and budgeting for prison health-care should be separated from general health-care provision for the entire country.

**g) Nutrition**

The quality and quantity of food given to the inmates was pitiable, imbalanced and inadequate. This was established through observation by the researcher within the time of data collection. There are various health side effects that may arise due to poor feeding practices. Women in general are vulnerable and more so if one is pregnant or lactating. A malnourished mother would impact on the fetus in the womb or the baby on the breast. The quality and amount of food especially to the vulnerable inmates in this study, sick, pregnant and lactating inmates should as a necessity be improved.

## **CHAPTER SIX: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

This chapter provides a summary of key findings obtained during the study. Conclusions have been drawn to explain the current status and recommendations for further research and issues of policy concerns are made. The main objective of this research was to establish the availability, utilization, quality and range of reproductive health services at Langa'ta Maximum Women's Prison. This project aimed at exploring and establishing the pattern of service and information provision related to reproductive health matters of women inmates, and at identifying gaps in the delivery of the same.

Health care provision is a challenge with reproductive health provision being a greatest hurdle especially so in the rural set up as was illustrated in the Literature Review. Similarly, prisons had been closed societies and little was known about their health provision, let alone social life. Prisons could only be heard of in times of epidemics when public health authorities would move in to arrest the situation or in times of daring escapes and so on.

The study focused on specific aspects of reproductive health-care, namely: ante-natal, post-natal, child immunization programmes, cancers both breast and cervix, HIV/AIDS and other STDs. Information from the field was collected by use of interview schedules, interview guides, and observation check list. Data analysis was done using SPSS. Research questions were adequately answered through summaries in the form of percentages and frequency tables as demonstrated in Chapter 4 of this project paper.

### **6.1 Summary of the Findings**

This section highlights the extent to which the research objectives were answered based on the findings of this research. Findings in this report were derived from in-depth analysis of first hand observations at the Langa'ta Maximum Women's prison, interviews with inmates, key informants, and policy makers. The following is a summary of the major findings:

#### **a) Reproductive health Interventions**

A few reproductive health interventions were being availed to the inmates. These were pre-natal, post-natal care, treatment of STIs and HIV/AIDS, immunization programmes

for children and health information. A healthy woman requires an all round care provision. It is however interesting to note that out the interviews conducted, the majority of inmates were somehow contented with the services since they indicated the services were average.

### **b) Quality and range of reproductive health**

The quality of reproductive health care is way below the internationally/nationally recognised standards as has been portrayed above. Women constitute a special category of vulnerable prisoners. Facilities are lacking and nurses handle all cases that require medical attention. These include but not limited to emergencies like deliveries which are ordinarily referred to KNH as there are no delivery kits within the prison.

There are too few staff to meet physical health needs. The time allocated for clinic visits is rather too short to have all clients given ample time for diagnosis. Everything is then handled in a hurry and quality of service is questionable. This often results in long delays in obtaining medical attention. The infirmary in the prison served both the inmates and the staff therein. This overstretched the facility in terms of staff, and drugs to the detriment of the inmates.

### **c) Viable ways of improvement**

A holistic approach to tackling health issues is of necessity as cited above. A prison should be viewed as a correctional facility and not a place to deny its occupants their basic rights like health. A prison should be made accessible to outsiders by reducing bureaucracy to less tedious levels.

### **d) Positive Feedback**

There are several positive and surprising revelations that characterize the women's prison. Hygiene standards are way above media portrayal and common belief.

Observation by the researcher indicated a maternity ward that had surprisingly very clean linen, conspicuously very neat floors and an absent foul smell that is a common feature in an unkempt health facility.

Health provider's attitude towards the staff was equally impressive. The language of communication between the providers and the prisoners was pretty friendly.

The services availed to the inmates are basically what is offered in a health centre/dispensary that is government sponsored. The staffs there in are mostly nurses just as outside the prison. This does not really quite agree with what the outside world perceives of prisons and no wonder then, a majority of inmates did say that the services availed to them are adequate.

## **6.2 Conclusions**

There are many avoidable factors that impede health care delivery at Langa'ta Maximum Women's Prison. These factors are like late referrals, inadequate facilities, poor patient management due to improper investigations and decisions about operative interventions. Cross infections due to inmates sharing beddings, linen and lack of isolation rooms for those with contagious diseases aggravate the health issues. It becomes more of a vicious cycle and running/management costs are at an all-time higher than the budget health allocation as indicated earlier. The study can conclude that there are a myriad of factors that hinder effective reproductive health care delivery at Langa'ta Maximum Women's Prison.

Of importance is the providers' attitude towards the inmates. The attitude of the health care providers was rated highly (refer to table 19 above) by pregnant inmates. A total of 73.3% indicated that they had not encountered any hostile care-giver. Nevertheless, 40% of the pregnant and lactating inmates indicated they had encountered hostile care givers. Manifestations of hostility from the inmates' perspective were more of operational issues as illustrated above.

The study appreciates lack of sexual harassment by the guards in the prison as table 21 indicates. This is a real contrast to what the media portrays. However, sexual harassment and/or consensual sex is evident beyond the prison walls as was reported by the key informants. The imbalance between inmates and guards sometimes involves indirect force based on the prisoners' total dependency on officers for basic necessities.

Instances of inmates going to court for mentions are a good example. Some women may be coerced into sex in order to avoid punishment and obtain favours.

### **6.3 Recommendations for Further Research**

Female inmates are an under-researched population who are often assumed to be equal to their male counterparts in terms of their health-care and prevention needs. Additional research is needed to identify the health-care issues specific to incarcerated women and the patterns and barriers to access and utilization of health-care services while incarcerated, and to design discharge planning and continuity of care programmes for the female offender upon release.

These findings were based on a small number of respondents; therefore, further exploration beyond this study is necessary. This study covered only one women's prison and there is need to cover all other women's prison to ensure a very good representation for generalization.

Reproductive health is dynamic in the sense that newer technology is being implemented every so often. Within the women's prison, there is need to research on other aspects of reproductive health that were not factored into this study. These are infertility; family planning before, during and after imprisonment; menopausal counseling and adolescent health.

There is equally need to research on the psychological impact of children serving sentences on behalf of their mothers.

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## Appendix 1

My name is Susan G. Maina. I am a Master of Arts (Medical Sociology) student at the University of Nairobi, Sociology Department. I am conducting a study on reproductive health of women inmates at Lang'ata Maximum Women's Prison. The study is exploratory since not much research has been done on this. The study anticipates to shed light on real health care provided at the prison, provide plausible recommendations and probably influence government policies as well as those of its development partners on the vulnerable group of women prisoners.

Any information given to me will be treated with utmost confidentiality. Your cooperation will be highly appreciated.

## Appendix 2

### Interview Schedule for Key Informants

Number of Interview Schedule.....

Date of interview.....

1. Occupation.....
2. Do you think HIV/AIDS is a serious problem in this community?  
1) Yes..... 2) No..... 3) I don't know.....
3. Do you have a V.C.T center? .....
4. What are the modes of transmission of HIV/AIDS for women in this community?  
.....  
.....
5. How do you provide information to women inmates regarding HIV/AIDS prevention?  
.....  
.....
6. Do you train the HIV positive inmates on behaviour change and positive living? Yes  
..... No.....
7. If,yes,,,explain,how?  
.....  
.....  
.....
8. What treatment procedures are in place for HIV positive inmates?.....  
.....  
.....
9. Do you think cancer is a serious problem in this community? (1)Yes... (2) No.....  
(3) I don't Know.....
10. What kinds of cancers affect women in this community?.....  
.....  
.....
11. How many times do you perform pelvic exams on a particular client within a period of one year? .....

12. What are the benefits to patients of having pelvic examinations?  
.....  
.....  
.....

13. If you do not perform pelvic examinations, where would your patients go to have one?.....  
.....

14. What makes it difficult for you to provide pelvic examinations?.....  
.....  
.....

15. Do you provide pap smears? Yes..... No.....

16. If no, where would your patients go to have one?.....

17. Do the benefits of conducting regular pap smear outweigh the effects of not having one done?  
.....  
.....

18. Would you like to provide these services? Yes..... No.....  
Why or why not?.....  
.....

19. What would you say about the cost involved in running the health care facility?.....  
.....  
.....

20. Do you think there is a direct relationship between the cost involved and the services provided at the facility? Please explain.....  
.....  
.....

21. How would you rate the quality of services in provision of reproductive health services provided at the facility?

- 1) Very good ( )
- 2) Good ( )
- 3) Average ( )
- 4) Bad ( )
- 5) Very Bad ( )

23. How would you rate the health providers' attitude to patients?

- 1) Very good ( )
- 2) Good ( )
- 3) Average ( )
- 4) Bad ( )

5) Very Bad ( )

24. How adequate is the health related information availed to inmates?

- 1) Very Adequate ( )
- 2) Adequate ( )
- 3) Average ( )
- 4) Inadequate ( )
- 5) Very Inadequate ( )

25. How adequate is the range of reproductive health services availed to women inmates?

- 1) Very adequate ( )
- 2) Adequate ( )
- 3) Average ( )
- 4) Inadequate ( )
- 5) Very Inadequate ( )

26. Have you received any training (short/ refresher courses) since you started working for this community?

Yes.....No.....

27. How long have you worked for this community?.....

28. Please tell me, are there cases of sexual assault within this institution? 1) Yes....

2) No.....

30. How many cases of sexual assault have you heard of/ or handled in the last three months?.....

31. Who are the perpetrators of those sexual assaults?.....

32. How do the authorities usually handle such cases?.....

33. What do you consider the most serious reproductive health problems that women in this community face?.....

34. How do you think the problems that hinder effective health care provision within this community would be solved?.....

35. What role do you think the government should play in addressing the problem?

.....  
.....  
.....  
.....

**Thank you for your answers.**

### Appendix 3

#### Interview schedule for pregnant inmates or inmates with children not more than one year old.

Date.....

#### Background Information.

1. Age.....
2. Religion.....
3. Marital status a) Married .... b) Widowed..... c) Divorced/ Separated..... d) Single.....
4. How long have you been here?.....

#### Gynecological History

5. How many months pregnant are you now? (Go to no. 7 for those with small babies).....
6. How many children do you have including those who do not live with you?.....
7. Did you see anyone for antenatal care for this pregnancy? If yes, whom did you see?  
1) Health professional....  
2) Doctor.....  
3) Nurse/ Midwife.....
8. During pregnancy, did you have any complications that required medical attention?.....
9. Where did you give birth to this baby?.....
10. Who attended the delivery of that child? .....
11. After leaving hospital, did you have any post delivery check ups? 1) Yes.....  
2) No.....
12. How many days or weeks after the delivery did the first check up take place?  
.....  
.....
13. During those visits did you receive information about
  1. Breastfeeding: Yes..... No.....
  2. Breast care: Yes..... No.....
  3. Child care: Yes..... No.....
  4. Nutrition: Yes..... No.....



5. Immunization: Yes..... No.....

15. How many times have you visited the health care facility in the last nine months? (Expectant women).

(Please tick where appropriate in the table below.)

5									
4									
3									
2									
1									
	Jan	Feb	Mar	April	May	June	July	Aug	Sept

16. How many times have you taken your child to the health care clinic in the last nine months?

(Please tick where appropriate in the table below.)

5									
4									
3									
2									
1									
	Jan	Feb	Mar	April	May	June	July	Aug	Sept

17. After leaving hospital, did a health care provider check on baby's health?

1)Yes.....2)No.....

18. Was the health check because the baby was sick or it was a routine health examination?.....

.....

19. Did you receive any special meal when pregnant and/or soon after birth?

1)Yes..... 2)No.....

20. If Yes, What?.....

.....

21. Have you encountered hostile health care givers? 1)Yes..... 2)No.....

22. If yes, explain.....

.....

.....

23. How long do you usually wait before you are attended to at the infirmary?.....

.....  
24. How would you rate the quality of services in provision of reproductive health services provided at the facility?

- 1. Very good ( )
- 2. Good ( )
- 3. Average ( )
- 4. Bad ( )
- 5. Very Bad ( )

24. How would you rate the health providers' attitude to patients?

- 1) Very good ( )
- 2) Good ( )
- 3) Average ( )
- 4) Bad ( )
- 5) Very Bad ( )

25. How adequate is the health related information given to inmates?

- 1) Very Adequate ( ) (2) Adequate ( ) (3) Average ( ) (4) Inadequate ( )
- (5) Very Inadequate ( )

26. How adequate is the range of reproductive health services availed to women inmates?

- 1) Very adequate ( ) 2) Adequate ( ) 3) Average ( ) 4) Inadequate ( )
- 5) Very Inadequate ( )

27. What do you think is the best way possible to solve problems that hinder smooth delivery of health care services in this community?.....

.....  
.....  
.....

28. Please tell me, are there cases of sexual assault within this institution? 1) Yes....  
2) No.....

29. How many cases of sexual assault have you heard of in the last three months?.....

30. Who are the perpetrators of those sexual assaults?.....

31. How do the authorities usually handle such cases?.....  
.....  
.....

32. What is the major reproductive health problem\concern of people in this community?  
.....  
.....

33. How do you think it should be addressed? .....  
.....

34. What role do you think the government should play in addressing the problem(s)?

.....  
.....  
.....  
.....  
.....

**Thank you for your answers**

## Appendix 4

### Interview Schedule for other general inmates.

#### Background Information

1. Age.....
2. Religion.....
3. Marital Status 1) Married..... 2) Single..... 3) Separated/ Divorced.....  
4) Widowed.....
4. How long have you been here?.....
5. What is the reproductive health service availed within this community?
  - 1) HIV/AIDS/ STIS
  - 2) Pre natal and Post natal care
  - 3) Cancers treatment
  - 4) Family Planning
  - 5) Others
6. How would you rate the quality of services in provision of reproductive health services provided at the facility?
  - 1) Very good ( )
  - 2) Good ( )
  - 3) Average ( )
  - 4) Bad ( )
  - 5) Very Bad ( )
7. How would you rate the health providers' attitude to patients?
  - 1) Very good ( )
  - 2) Good ( )
  - 3) Average ( )
  - 4) Bad ( )
  - 5) Very Bad ( )
8. How adequate is the health related information given to inmates?
  - 1) Very adequate ( ) (2) Adequate ( ) (3) Average ( ) (4) Inadequate ( )
  - (5) Very Inadequate ( )
9. How adequate is the range of reproductive health services availed to women inmates?
  - 1) Very adequate ( ) 2) Adequate ( ) 3) Average ( ) 4) Inadequate ( )
  - 5) Very Inadequate ( )

10. How many times have you visited the health care facility in the last nine months?  
 (Please tick where appropriate in the table below.)

5									
4									
3									
2									
1									
	Jan	Feb	Mar	April	May	June	July	Aug	Sept

**Information on reproductive health cancers**

11. Have you ever heard of cervical or breast cancer?.....

12. What are the effects of cervical cancer to

1) the individual?.....

.....

.....

2) the family?.....

.....

.....

3) the community?.....

.....

13. Have you ever had a pap smear test while you are here?

.....

14. If not, why?.....

.....

15. Have you had a breast examination while you are here?.....

16. Do you ever do breast self examination?.....

.....

17. If yes, how often and if no, why not?.....

.....

**Knowledge on HIV/AIDS and STIS.**

I am now going to read some statements to you about HIV/AIDS and other STIs. Please tell me if it is true or false or you don't know.

18. One can always tell when a person has a sexually transmitted infection.....
19. I can tell if a person is HIV positive. ....
20. If signs of STIs disappear, it means the person no longer has the disease.....
21. A healthy looking person can be infected with AIDS virus.....
22. A woman with HIV/AIDS will always give birth to a child with AIDS virus.....
23. You can get AIDS from
- 1) Shaking hands with someone who has AIDS .....
  - 2) Hugging someone who has AIDS.....
  - 3) Wearing clothes for one who has .....
  - 4) Sharing utensils with one who has.....
  - 5) Mosquitoes, flees or bedbug bites.....
  - 6) Unprotected sex with a HIV positive partner
24. In general, what has been the your most important source of information about STDs including HIV/AIDS?.....  
 .....  
 .....  
 .....

**Knowledge on abortion**

25. Do you think a woman always has the right to decide about her pregnancy, including whether or not to have an abortion?.....
26. If yes, why and if no, why not?.....  
 .....  
 .....
27. Under which of the following conditions is it all right for a woman to have an abortion? (Tick where appropriate)
- 1) Her life is endangered by the pregnancy
  - 2) The fetus has a physical deformity
  - 3) Pregnancy has resulted from rape
  - 4) Her health is endangered by the pregnancy
  - 5) She is unmarried
  - 6) The couple cannot afford to have a(nother) child.
28. Have you encountered hostile health care givers? 1) Yes..... 2) No.....
29. If yes, explain.....  
 .....  
 .....

30. How long do you usually wait before you are attended to at the infirmary?.....  
.....  
.....
31. Have you suffered from any reproductive health problem since you came here?  
.....
32. If yes, which one?.....
33. Did you receive any medical care when you needed it? If yes, explain.....  
.....  
.....
34. Please tell me, are there cases of sexual assault within this institution? 1) Yes....  
2) No.....
35. How many cases of sexual assault have you heard of in the last three months?.....  
.....
36. Who are the perpetrators of those sexual assaults?.....
37. How do the authorities usually handle such cases?.....  
.....  
.....
38. What role do you think this community should play in addressing major reproductive health needs?.....  
.....  
.....
39. What role do you think the government should play in addressing the problem?  
.....  
.....  
.....

**Thank you for your answers**

## Appendix 5

**Facilities/ equipments to assess. Their availability and if they are there, are they in a working condition?**

1. Blood pressure machine
2. Baby weighing scales
3. Stethoscope
4. Examination Table
5. Antenatal/ immunization forms
6. Source of light in labour rooms- electricity, generator, candles, battery torch, or kerosene lamps
7. Ambulance/ vehicle to conduct emergency transfers
8. Public/ private phone, radio call facility
9. Others



## Appendix 6

### Interview guide for policy makers at the Ministries of Health and Home Affairs.

#### Interview will be guided by the following

1. Greatest health need and the community demands
2. Reproductive health interventions offered there in
3. Institutional capacity of the health care facility at the prison
4. Costs involved in running the health care facility and their implication on service provision
5. Supplies to the facility—source, adequacy, reliability and accountability of the same
6. Staffing needs in terms of size, motivation, refresher courses
7. Quality of services provided at the institution
8. Attitude of health care givers