



March 26, 2020

The Committee Against Torture

RE: Supplementary information for the Republic of Kenya, scheduled for review by the Committee against Torture during its 69th session, Geneva, 20 April to 15 May 2020

Honourable Committee Members:

The Center for Reproductive Rights (the Center) submits this letter to the Committee Against Torture (the Committee) ahead of its adoption of list of issues for Kenya during its 69th Session. The Center is a non-profit legal advocacy organization dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at the national, regional, and international levels to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfil. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in fifty nations in Africa, Asia, Europe, Latin American and the Caribbean, the United States, and through in-depth engagement with UN and regional human rights bodies.

This letter highlights the various reproductive health and rights issues that the Center hopes the Committee will consider while reviewing Kenya’s compliance with the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention). Namely **(i) High maternal mortality and inadequate access to maternal health care; (ii) Inadequate access to abortion and post-abortion care services (iii) Sexual and gender-based violence during election and post-election period (iv) Inadequate access to contraceptives and family planning information and services (V) Criminalization of noncoercive and nonexploitative sexual conduct among adolescents**

A. High Maternal Mortality and Inadequate Access to Maternal Health Care

The lack of access to dignified and quality reproductive health services, including maternal health services, may constitute ill and degrading treatment hence a violation of the Convention. The Committee has previously raised concerns over the ill-treatment of women seeking reproductive health services specifically maternal health services. For instance, in 2013, while reviewing the government of Kenya, “the Committee remained concerned about ill-treatment of women who seek access to reproductive health services, in particular the ongoing practice of post-delivery detention of women unable to pay their medical bills, including in private health facilities.”¹ The Committee recommended to the government of Kenya “to

¹ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, concluding observations on the second periodic report of Kenya, adopted by the Committee at its fiftieth session para 27, U.N Doc. CAT/C/KEN/CO/2 (2013) (*hereinafter CAT Concluding Observations, Kenya, 2013*)

strengthen its efforts to end the practice of forcible detention of post-delivery mothers for non-payment of fees, including in private health facilities.”²

Access to quality and dignified maternal health care

Detention of women post-delivery remains pervasive. In 2015, the High Court of Kenya issued a ground-breaking decision on detention of women seeking maternal health services. The petitioners, two women from low economic backgrounds were detained in a government health facility post-delivery due to inability to pay medical fees. While being detained, the women were denied basic medical care, forced to sleep on the floor and one of them acquired an infection. In its ruling, the court stated that such practices violated women’s right to not be deprived of freedom arbitrarily, right to dignity, right to health, right to be free from discrimination and right to be free from inhuman treatment and punishment.³ The court ordered the Ministry of Health (MoH) to develop clear guidelines and procedures for implementing the waiver system in all public hospitals. ⁴The court further ordered MoH and County government of Nairobi to take the necessary administrative, legislative, and policy measures to eradicate the practice of detaining patients who cannot pay their medical bills.⁵

These orders are yet to be implemented. To date, several women and especially those with lower socio-economic status continue to be detained post-delivery due to inability to pay medical bills.⁶ In March 2019, MoH appeared before the Parliamentary Health Committee to explain the magnitude of detention of patients due to inability to pay medical bills in public and private facilities. According to the MoH’s report, out of the 216 health facilities that had provided data, 10 facilities at national and county level reported to be holding 300 patients due to non-payment of medical bills. ⁷Among these were 184 patients being detained at Kenya’s national referral hospital for approximately Kshs 6 billion (approximately 60,000, 000 million USD) debt.⁸ MoH acknowledged that detention of patients due to non-payment is an on-going challenge and reported that a special technical team had been constituted to investigate whether patients are being held in confined rooms for non-payment of medical bills.⁹ Though MoH had committed to publish the report of the investigations within one month, the report is still not publicly available.

Women seeking maternal health care face a high risk of ill-treatment, particularly immediately before and after childbirth. Poor quality of care remains a leading contributor to maternal deaths in Kenya. In 2014, the Center filed a petition at the High Court of Kenya challenging the mistreatment and physical abuse of a woman who went to deliver in a government health facility and was forced to deliver on the floor.¹⁰ In 2018, the High Court of Kenya declared that the “physical and verbal abuse meted out on the petitioner

² CAT Concluding Observations, Kenya, 2013, para 27

³ M A & Another v Honorable Attorney General & 4 others [2016]

⁴ M A & Another v Honorable Attorney General & 4 others [2016]

⁵ M A & Another v Honorable Attorney General & 4 others [2016]

⁶ Angela Oketch & Verah Okeyo, Agony of women detained in hospitals over bills (2017) available at <https://www.nation.co.ke/news/Agony-of-women-detained-in-hospitals-over-bills-/1056-4231498-jys62wz/index.html>; see also Lucy Minayo & Betty Odallo, ‘Detention of patients, bodies illegal’ (2019) available at <<https://www.nation.co.ke/oped/opinion/Detention-of-patients--bodies-illegal/440808-5065496-15ccj27z/index.html>>

⁷ Ministry of Health, ‘Responses to various matters pending at the departmental committee on Health’ (Copy of the report in file with the Center), see also Wangui Ngechu, ‘KNH detaining patients, bodies over Kshs. 6B debt, Ministry says’ (2019) available at < <https://citizentv.co.ke/news/knh-detaining-patients-bodies-over-ksh-6b-debt-ministry-says-238070/>>

⁸ Id.

⁹ Id.

¹⁰ Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 6 (High Ct. Kenya, Bungoma) (on file with the Center for Reproductive Rights).

during delivery amounted to a violation of the right to dignity and right not to be subjected to cruel inhumane and degrading treatment.” The Court also found that the National and County Government had failed to implement and/or monitor the standards of free maternal health care and services, thus resulting in the mistreatment of the petitioner and the violation of her rights.¹¹ The Court directed and ordered a formal apology to the Petitioner and awarded the Petitioner Kshs 2,500, 000 (equivalent of 25000 USD) for infringement of her rights. While the County has made efforts and carried out some reforms including improving the infrastructure and working closely with grassroots organizations to improve services, the national government is yet to address the issues holistically. According to a 2017 Confidential Enquiry on maternal deaths by the Ministry of Health, 9 out 10 women die due to poor quality of care by health professionals.¹² Additionally, the Confidential Enquiry shows that these deaths could have been prevented by improving the care for 88.1% of women who died.¹³

The Confidential Enquiry further shows that 73.3% (355) of maternal deaths occurred outside working hours (after 5pm to before 8am), on weekends and public holidays. 26.7% (129) died during weekday normal working hours (8am- 5pm).¹⁴ These findings attest to media reports of women and especially those in remote areas dying due to lack of services outside working hours and distance to health facilities.

For instance, in 2018 a woman went to deliver in a public health dispensary facility in Kwale County, one of the remotest areas in Kenya. On arrival, she and her family found out that the dispensary had been closed and nobody to assist. The woman died later while the family sought alternative health facilities where she could deliver.¹⁵ Several factors led to her preventable death including lack of transport and distance to the facility. According to KDHS 2014, distance to health facility is the second leading barrier to women accessing quality maternal health care.¹⁶

Access to skilled medical personnel

Access to skilled medical personnel is fundamental for ensuring safe pregnancy and delivery, as well as for preventing maternal and newborn deaths and related long-term health issues. When women and girls do not have access to skilled medical personnel, provision of quality services may be challenging resulting in physical and mental suffering which may amount to torture or cruel inhumane and degrading treatment (CIDT). Women may also suffer negligent or poor-quality services which may lead to mental suffering. For instance, women may be forced to travel long distance looking for health facilities that have skilled personnel or face serious complications due to delays in service provision caused by lack of skilled medical personnel. By 2015, Kenya had 5,660 doctors which translated to approximately 1.5 doctors per 10,000 of

¹¹ J O O (also known as J M) v Attorney General & 6 others [2018] eKLR available at <http://kenyalaw.org/caselaw/cases/view/150953/>

¹² Ministry of Health, *Saving Mothers Lives, Confidential Enquiry into Maternal Deaths in Kenya, First Report* 2017, at 5, available at < <https://cmnh.lstmed.ac.uk/sites/default/files/content/centre-news-articles/attachments/CEMD%20Main%20Report%20Sept%203%20FINAL-%20Full%20Report.pdf>>

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Lawrence Nganga, ‘Pregnant woman dies after being locked outside hospital gate’, CITIZEN DIGITAL (May 6 2018) available at <<https://citizentv.co.ke/news/pregnant-woman-dies-after-being-locked-outside-hospital-gate-199259/>> ; Interview report conducted by the Center for Reproductive Rights on 11th May 2019 (report in file with the Center).

¹⁶ Kenya Demographic and Health Survey 2014, at 136. (hereinafter 2014 KDHS) available at <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

the population, against the WHO recommended minimum staffing level of 36 doctors per 10,000.¹⁷ This is aggravated by health professionals' industrial strikes and continuous threats to withdraw services. In December 2016, doctors went on strike for more than 100 days citing low remuneration and lack of proper equipment as adversely affecting their capacity to deliver quality services. This led to withdrawal and interruption of key maternal health services and in certain instances women being forced to deliver outside health facilities and others losing their lives.¹⁸ Similarly, on June 5, 2017, nurses went on a national strike for over 150 days demanding a pay rise.¹⁹ Despite the government reaching an agreement with doctors and nurses, a lot of uncertainty remains with the health professionals threatening to withdraw their services from time to time.²⁰

B. Inadequate Access to Abortion and Post-abortion Care Services

The Committee has repeatedly expressed concern about restrictions on access to abortion and about absolute bans on abortion as violating the prohibition of torture and ill-treatment.²¹ The Committee has also made the link between restrictive abortion laws and high rates of maternal mortality and recommended that states include exceptions in their abortion laws for sexual violence, or to protect the life and health of the pregnant woman.²² Similarly, the Human Rights Committee in its landmark decision of *K.N.L.H. v. Peru*, deemed the denial of a therapeutic abortion a violation of the individual's right to be free from ill-treatment.²³ Additionally, The UN Special Rapporteur on Torture has acknowledged reports of health providers withholding care "that intentionally or negligently inflict[s] severe pain or suffering for no legitimate medical purpose" and found that "[t]he withholding of medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or punishment, and if there is State involvement and specific intent, it is torture."²⁴

Access to safe and legal abortion services

Unsafe abortion is one of the leading contributors to high maternal mortality rates in Kenya. According to the most recent study by the African Population and Health Research Center (APHRC) and the Ministry of Health (MoH), about half a million induced abortions occurred in the country in 2012. Most of these

¹⁷ Ministry of Health (KENYA), Kenya Health Workforce Report: The Status of Healthcare Professionals in Kenya, 2015) at 10, available at <https://www.taskforce.org/wp-content/uploads/2018/07/KHWF_2017Report_Fullreport_042317-MR-comments.pdf>

¹⁸ Mary Kulundu, *Patients die, others, abandoned as doctors strike*, (21 August 2018) available at <https://www.kenyans.co.ke/news/patients-die-others-abandoned-doctors-strike-begins-kenya> see also Gatonye Gathura, *Doctors pain on needles deaths during 100-day strike*, STANDARD DIGITAL (21st April 2018) available at <https://www.standardmedia.co.ke/article/2001277669/how-kenyans-died-during-100-day-doctors-strike>

¹⁹ Majanga Michael, *Nurse call off strike after 150 days*, CITIZEN DIGITAL (November 2, 2017) available at <https://citizentv.co.ke/news/nurses-call-off-strike-after-150-days-180760/>; see also Stellar Murumba 'A look at the misery that is the life of Kenyan nurses', Business Daily (October 5, 2017) available at <https://www.businessdailyafrica.com/corporate/Nurses-strike--The-long-struggle-for-better-pay/539550-4126544-ueX4h/index.html>; Dannish Odongo *Five Months Nurses' Strike Called Off* Capital News (November 2 2017) available at <https://www.capitalfm.co.ke/news/2017/11/five-months-nurses-strike-called-off/>

²⁰ Dzuya Walter, *relief as nurses' strike is called off*, CITIZEN DIGITAL, (February 26, 2019) available at <https://citizentv.co.ke/news/relief-as-nurses-strike-is-called-off-233266/>, see also Kevine Omollo, *yet again: nurses issue a 21 day strike notices*, STANDARD DIGITAL (17 November, 2018) available at <https://www.standardmedia.co.ke/article/2001303033/nurses-in-yet-another-strike-threat>

²¹ See CAT/C/PER/CO/4, para. 2; General comment No. 28, para. 11;

²² *id* para 23;

²³ *K.L. v. Peru*, CCPR/C/85/D/1153/2003, Communication No. 1153/2003 (2005), para. 6.3.

²⁴ Special Rapporteur on torture and other forms of cruel, inhuman and degrading treatment, A/HRC/22/53, para. 39

abortions were unsafe and resulted in various complications. The laws governing abortion in Kenya remain confusing and contradictory. While Kenya's 2010 Constitution provides for abortion in situations where a woman's life or health is at risk,²⁵ the Penal Code has not been revised to reflect this change.²⁶

The MoH made the confusion surrounding the legality of abortion worse by withdrawing its 2012 *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya*, which provided guidance to medical professionals as to when they could perform abortion services under the 2010 Constitution.²⁷ In addition, in 2014, the MoH issued a memo to all health care providers stating that "abortion on demand is illegal" without clarifying the legal exception under the Constitution.²⁸ The memo further stated that it is illegal for health workers to participate in trainings on either safe abortion care or the use of the drug Medabon for medical abortion.²⁹ The memo threatened health workers with legal and professional sanctions, even though trainings are essential to the development of health workers' skills in comprehensive and life-saving abortion care. The Committee has recognized that lack of legal clarity "leads to serious consequences in individual cases" and has in its reviews urged states to establish clear statutory guidelines for legal abortion and adequate service provision to ensure compliance with the Convention.³⁰ The Committee has stated that acts resulting from this lack of clear guidance may amount to CIDT³¹

In 2013, the Committee while assessing Kenya's compliance with its obligations under the Convention raised concerns "that there is no right to abortion in such cases [rape and incest] and, as a consequence, women are left in an unjustified discretionary situation with grave repercussions on their health due to the resulting uncertainty for women and medical doctors."³² The Committee recommended that "that the State party amend its legislation in order to grant women who have been subjected to rape or incest the right to abortion independently of any medical professional's discretion."³³ The Committee further recommended that Kenya "evaluates the effects of its restrictive legislation on abortion on women's health with a view to regulating this area with sufficient clarity."³⁴

Seven years later, Kenya is yet to fully implement these recommendations. The story of JMM a schoolgirl, who was sexually abused, procured unsafe abortion, and could not get appropriate post-abortion care leading to lifelong complications, then later her death, demonstrates the impact of lack of clarity on abortion in Kenya.

JMM, a schoolgirl from a poor family in rural Kisii, was born in 2000. Her mother, PKM, is a casual laborer, earning about Kshs. 100 (approx. USD 1) a day. When JMM was 14 years old, she

²⁵ CONSTITUTION art. 26(4) (KE).

²⁶ The Penal Code (2009) Cap. 63 158-160 (Kenya).

²⁷ See, e.g., John Muchangi, *Kenya: Alarm Over Rise in Unsafe Abortions in the Coast*, The Star (Mar. 4, 2015), available at <http://allafrica.com/stories/201503061533.html> [hereinafter Muchangi, *Alarm Over Unsafe Abortion*]; Joyce Chimbi, *Kenya: A Society at Crossroads Over Devastating Impact of Unsafe Abortions*, The Star (Feb. 16, 2017), available at <http://aphrc.org/post/4099>.

²⁸ Ministry of Public Health and Sanitation, Memo to health care providers on abortion training and Medabon (2014)
²⁹ *Id.*

³⁰ CAT Committee, *Concluding Observations: Ireland*, para. 26, U.N. Doc. CAT/C/IRL/CO/1 (2011).

³¹ CAT Committee, *Concluding Observations: Ireland*, para. 26, U.N. Doc. CAT/C/IRL/CO/1 (2011).

³² Kenya CAT COs, para 28.

³³ Kenya CAT Cos, para 28.

³⁴ Kenya CAT Cos, para 28.

was forced into sexual intercourse by an older man. She suspected that she could be pregnant after two months when she started feeling nauseous. As is the case with many rape survivors, JMM did not receive information on post rape care. Aware of the blame always placed on rape survivors and fearing that she would be held responsible and rejected by society, she turned to the only person she thought would help her without judging her – an older girl with whom she shared a bedroom. The girl introduced her to an unqualified provider who helped her procure an unsafe abortion. After the procedure, JMM was advised to go home and wait for the completion of the abortion process. At home, she began vomiting and bleeding heavily. She was taken to a nearby dispensary that was not well equipped. Besides, the dispensary lacked skilled staff. After a few hours, JMM was transferred to Kisii County Referral Hospital, the highest-level public facility in that county, located about 15.6 Km away from her home. She stayed at the hospital for three nights and received some treatment. The hospital established that JMM needed specialized treatment, a service they could not provide. She was therefore referred to Tenwek Mission Hospital for dialysis, a hospital of a lower classification, located about 50 Kms away. At Tenwek, JMM was immediately admitted to the intensive care unit. By this time, she could not talk. She was discharged from Tenwek after seven days without adequate treatment on the grounds that the hospital did not have a dialysis machine and could therefore not provide the services for which she had been referred and admitted.

Twelve days after the unsafe abortion, JMM arrived at Kenyatta National Hospital – (KNH) the biggest referral hospital in the country – where she received post abortion care and dialysis. KNH diagnosis indicated that she had a septic abortion, hemorrhagic shock and had developed chronic kidney disease. About 68 days later, she was discharged but was detained at the facility as she was unable to pay for the hospital bill that had risen to Kshs. 39,500 (approximately USD 395).

Consequently, she slept on a mattress on the floor at a “detention center” in the hospital. She fell sick again and was taken to the main hospital for treatment for four days and later returned to “detention” for a further two weeks before her bill was finally waived when the hospital established, she could not pay. JMM lived with kidney disease arising from the unsafe abortion for three years and required dialysis every month. She passed away in June 2018 due to complications from the kidney disease.

In June 2015, the Center had filed a case in the High Court of Kenya that challenged the Ministry of Health’s memo and the withdrawal of the Standards and Guidelines. The objective of the case was to ensure that the Standards and Guidelines are reinstated so that there is certainty around access to and provision of legal and quality abortion and post-abortion care services in Kenya, as well as to ensure that healthcare providers are able to be trained in order to know how to carry out safe abortions. The case was also aimed at ensuring redress for JMM, who was alive at the time, for the mental and emotional harm caused by her suffering.

On 12th June 2019, the High Court of Kenya delivered a judgment on the case and declared that the right to health, life, non- discrimination, consumer rights, information and right to scientific progress of women and girls of reproductive age had been infringed upon and threatened by the actions of MoH.³⁵ The Court further declared that MoH violated the rights to information, expression and association and the right to

³⁵ Federation of Women Lawyers & 3 Others Vs the Attorney General & 2 Others, Constitutional Petition No 266 of 2015. available at <http://kenyalaw.org/caselaw/cases/view/175490/>

scientific progress of the health providers by its action of banning trainings on abortion; and that the directive banning training of health professionals on abortion and the Memo withdrawing standards and guidelines on abortion are unlawful, illegal, arbitrary and null and void.³⁶ Additionally, the Court quashed the directive and letter thereby reinstating the standards and guidelines, and training of health professionals on abortion in accordance with the Constitution.³⁷ With regards to victims of sexual violence, the court declared that if in the opinion of a trained health professional a pregnancy resulting from rape and defilement poses a danger to the life or health, including mental health, of a pregnant woman, the pregnant woman is entitled to an abortion.³⁸ The Court also awarded PKM, JMM's mother, 3 million shillings (approx. USD 30,000) for mental and emotional harm caused by suffering of JMM and ordered the government to pay the damages.³⁹ Despite this being a groundbreaking decision, some sectors have expressed dissatisfaction and have filed an appeal. Additionally, MoH is yet to comply with Court orders eight months later and this continues to impact women and girls' access to safe legal abortion.

Access to post-abortion care services

The Committee has expressed particular concern about the practice of denying care to women who have suffered complications from illegal abortions, conditioning the provision of life-saving post-abortion care (PAC) on obtaining confessions from women about having undergone illegal abortions, and obliging physicians to bring information on women requiring PAC to the attention of the authorities.⁴⁰ Women who are denied PAC can also face intense shame and stigmatization as well as fear of criminal reprisals. The denial of care or the provision of inferior care can clearly cause severe physical and mental pain and suffering. The Special Rapporteur on Torture has made an explicit link between the denial of pain relief and the prohibition of torture and CIDT and has affirmed that such a denial constitutes CIDT if it causes severe pain and suffering.⁴¹

Access to PAC is essential to protect the health and lives of women—particularly in Kenya where the rate of unsafe abortion and resulting complications remain high. According to the APHRC and MoH study on the Cost of PAC in Kenya, in 2012 the government of Kenya spent approximately 432.7 million shillings (approx. US\$5.1 million).⁴² Most of the funds was spent on the treatment of severe medical complications. In 2016, the treatment costs for these complications in public facilities was estimated to be 533 million shillings (about US\$6.3 million).⁴³

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Committee against Torture, Concluding Observations : Nicaragua U.N. Doc CAT/C/NIC/CO/1 (2009), Committee against Torture, Concluding Observations: Peru U.N Doc CAT/C/PER/CO/5-6 (2012) , Committee against Torture, Concluding Observations: Paraguay U.N Doc CAT/C/PRY/CO/4-6 (2011) , Committee against Torture, Concluding Observations: Chile U.N Doc CAT/C/CR/32/5, Committee against Torture, Concluding Observations: Philippines U.N CAT/C/PHL/CO/3.

⁴¹ Manfred Nowak, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social, and Cultural Rights, Including the Right to Development, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman, and Degrading Treatment and Punishment, (7th Session A/HRC/7/3) (15th January 2008) available at <https://www.refworld.org/docid/47c2c5452.html>

⁴²Ministry of Health, 'The Costs of Treating Unsafe Abortion Complications in Public Health Facilities in Kenya', (February, 2018), available at https://aphrc.org/wp-content/uploads/2019/07/The-Costs-of-Treating-Unsafe-Abortion-Complications-in-Public-Health-Facilities-in-Kenya_Final.pdf

⁴³ *Id.*

According to a 2018 study conducted in sixteen health facilities in three regions in Kenya, provision of quality PAC in healthcare facilities in Kenya is still low. The study shows that restrictive abortion laws, stigma towards abortion, intermittent service interruptions through industrial strikes and inequitable access to care are key drivers leading to unsafe terminations.⁴⁴ The study further indicates, poor PAC service availability and lack of capacity to manage complications in primary care facilities result in multiple referrals and delays in care following abortion, leading to further complications.⁴⁵ Additionally, the study found that uncertainty around legality of abortion led to discrimination of women and girls seeking PAC services at healthcare facilities. Service providers often condemned abortion and discriminated against women who secured abortion and did not always support patients' healthcare needs causing delays in care provision.⁴⁶ According to National Post Abortion Care Curriculum for Service Providers, PAC "is legal and not punishable by any part of Kenya [sic] laws." Additionally, the MoH has developed PAC guidelines. However, these guidelines are yet to be officially launched and information disseminated to women and girls.

C. Sexual and Gender-Based Violence During Election and Post-Election Period

The Committee has consistently addressed the sexual and reproductive rights of victims of sexual violence. For instance, in its review of states the Committee has emphasized the need to provide emergency contraceptives to victims of sexual violence and access to safe and legal abortion.⁴⁷

Despite chronic underreporting, data from various sources demonstrate that violence against women, sexual and otherwise, remains prevalent in Kenya. The 2014 KDHS shows that 39% of ever-married women reported having experienced sexual or physical violence by their husband or partner,⁴⁸ which is not a significant decrease from 2008-2009 KDHS which showed that 47% of ever-married women reported having experienced such violence.⁴⁹ In addition, roughly 28% of women aged 20-29 had experienced some form of violence by a husband or partner in the previous 12 months preceding the 2014 survey.⁵⁰ Women in vulnerable situations face higher risk of experiencing sexual and gender based violence. For instance, women and girls in conflict and crisis areas are disproportionately affected by sexual and gender-based violence.

In May 2015, the President signed into law the Protection against Domestic Violence Act⁵¹ which criminalizes a wide range of gender-based violence including marital rape, economic and sexual abuse, and harmful traditional practices such as female genital mutilation.⁵² It also sets out protection mechanisms for victims, such as counseling and medical assistance, as well as protection orders against the perpetrator.⁵³

⁴⁴ Mutua MM, Manderson L, Musenge E, Achia TNO. Policy, law and post-abortion care services in Kenya. PLoS One. 2018 Sep 21;13(9): e0204240. doi: 10.1371/journal.pone.0204240. PMID: 30240408; PMCID: PMC6150499 available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6150499/>

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ See e.g. CAT Committee, Concluding Observations: Paraguay, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); El Salvador, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); Nicaragua, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009)

⁴⁸ KDHS 2014, *supra* note 13, at 291.

⁴⁹ KDHS 2008–09, *supra* note 11, at 253.

⁵⁰ KDHS 2014, *supra* note 13, at 314, tbl. 16.12.1.

⁵¹ *Kenya: Uhuru Signs Domestic Violence Bill Into Law*, THE STAR, May 14, 2015 available at <https://allafrica.com/stories/201505150096.html>

⁵² See, The Protection Against Domestic Violence Act (2015), KENYA GAZETTE SUPPLEMENT NO. 60 (ACTS NO. 2) (2015).

⁵³ *Id.*

Prior to that, the Victim Protection Act⁵⁴ was passed in 2014. It provides for the protection of victims' privacy and confidentiality, and support through special protection and compensation, as well as reparations.⁵⁵ Despite the existence of this legal framework, sexual and gender-based violence during electioneering periods remains prevalent in Kenya. According to a 2018 report by the Kenya National Commission on Human Rights, two hundred and one (201) cases of sexual violence were reported from eleven counties following the 2017 election.⁵⁶ This information highlights counties that are considered hotspots for election violence and the numbers could be higher if the mapping included all the 47 counties. According to the report, sexual and gender-based violence was perpetrated more by the police at 54.5% compared to civilians at 45.5%.⁵⁷ Gang rape and rape accounted for over 71% of cases recorded and about 9% of cases affected minors aged between 7 years to 17 years old.⁵⁸ In some instances, pregnant women were gang raped exposing them to pregnancy-related complications.⁵⁹ In other situations, married women sought abortion services confidentially mainly because of the stigma that surrounds abortion services in Kenya despite the law permitting abortion in cases of sexual violence.⁶⁰ Other long-term implications included victims contracting HIV infections, sexually transmitted infections, physical trauma, and, some adolescent girls were forced to drop out of school.⁶¹

In 2017, the CEDAW Committee expressed its concern at “reports of election-related gender-based violence, including sexual violence, against women during the 2017 elections, and the delay and apparent lack of commitment by the State party to prosecute perpetrators and provide reparations to victims of election-related gender-based violence.”⁶² The CEDAW Committee recommended that the government “*prosecute perpetrators of gender based violence, including sexual violence, that took place during both the 2017 and the 2007-2008 elections, and ensure full implementation of the report of the Commission of Inquiry into the 2007-2008 Post-Election Violence.*”⁶³ It urged the government to “*Ensure adequate provision of reparations and provide support, including psychological and physical support to women victims of such violence.*”⁶⁴ The CEDAW Committee further recommended that the government “*Ensure a human rights-based approach to law enforcement during elections, and issue guidelines on the protection of women and girls, including in educational institutions, during elections.*”⁶⁵

These recommendations are yet to be implemented and the 2018 report by the Kenya National Commission on Human Rights clearly shows that government is yet to take appropriate measures to prosecute perpetrators of sexual and gender-based violence during electioneering period. Also, it is yet to ensure reparation and compensation to victims and put in place measures to prevent sexual and gender-based violence during election periods.

⁵⁴ Victim Protection Act (2014), KENYA GAZETTE SUPPLEMENT NO. 143 (ACTS NO. 17)

⁵⁵ *A New Era for Victims of Crime in Kenya*, BOWRY & CO. ADVOCATES (Jan. 21, 2016), available at <http://bowrycoadv.com/a-new-era-for-victims-of-crime-in-kenya/>.

⁵⁶ *Silhouettes of Brutality: An account of sexual violence during and after the 2017 General Election*, at 31, available at https://www.knchr.org/Portals/0/KNCHR_Silhouettes_of_Brutality.pdf

⁵⁷ *Id.*, at 32.

⁵⁸ *Id.*, at 37.

⁵⁹ *Id.*, at 67.

⁶⁰ *Id.*, at 68.

⁶¹ *Id.*, at 69.

⁶² Committee on the Elimination of Discrimination against Women, Concluding Observations on the Eighth Periodic Report of Kenya U.N. Doc. CEDAW/C/KEN/CO/8 (2017), Para 24 (a).

⁶³ *Id.*, Para 25 (a).

⁶⁴ *Id.*, Para 25 (b).

⁶⁵ *Id.*, Para 25 (c).

D. Inadequate Access to Contraceptives and Family Planning Information and Services

The Committee recognizes that lack of access to contraception, and especially oral emergency contraception to victims of rape, may constitute torture or CIDT. For instance, in its 2012 concluding observations for Peru, the Committee for the first time raised the issue of lack of access to contraception as a form of torture or CIDT, expressing concern about the lack of access to oral emergency contraception to victims of rape and classifying the practice as potentially torture or CIDT.⁶⁶ The Committee then called on Peru to remove legal restrictions on the distribution of emergency contraception to rape victims.⁶⁷ Similarly, the Special Rapporteur on Torture, in his report to the Human Rights Council, recognized that “[a]ccess to information about reproductive health is imperative to a woman’s ability to exercise reproductive autonomy, and the rights to health and to physical integrity,” recognizing that the denial of such information can cause severe physical or mental suffering and amount to torture or CIDT.⁶⁸

A large portion of Kenyan women have an unmet family planning need but are not currently using a contraceptive method. Although women from all demographic backgrounds have significant unmet family planning needs, the rate of unmet need falls precipitously as wealth increases with a rate of 24% unmet need in the lowest wealth quintile and only about 10% in the highest quintile. In addition, usage disparities are even more pronounced by geographic area due to factors including inequitable regional distribution of contraception and frequent stock outs. For example, only 3.4% of women in the former North-eastern Province—a region with low socio-economic indicators—use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.

These disparities in usage rates are due to a variety of barriers to women’s and adolescent girls’ access to family planning information and services. According to a 2018 baseline survey conducted in five counties in Kenya by the Center and Trust Indigenous Culture for Health (Center-TICAH baseline survey), public health facility stock-outs, inequitable distribution of contraceptives, and costs associated with procuring contraceptives, such as lost wages or transportation, stigma and lack of accurate and comprehensive information are key barriers to access to family planning services. Further despite the MoH policy that contraceptives should be available free of charge, many government health facilities charge their patients “user fees” for family planning services and some charge for the contraceptive method itself. Moreover, women’s preferred methods of contraception are often unavailable or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members. This results in emotional suffering with some of them being forced not to continue usage. Additionally, the patriarchal nature of certain communities in Kenya has forced many women not to have access to contraceptive services. During the interviews and focused group discussions, women reported that they had to seek permission from their husbands before getting contraceptives and in some instances, they narrated how they were forced by spouses to remove the contraceptives with some men accompanying them to the health facility and demanding that the contraceptive be reversed.

Misinformation is a leading barrier to accessing contraceptives. During the survey, women and adolescent girls reported inadequate access to accurate and comprehensive information on family planning services. Majority relied on their friends and peers, radio advertisements and health talks at health facilities. In most cases the information was inaccurate and misleading. Some of the myths and misconceptions shared during the interviews included: “family planning methods cause “cancer,” “infertility,” “mental illness,” “severe

⁶⁶ CAT Committee, *Concluding Observations: Peru*, para. 15, U.N. Doc. CAT/C/PER/CO/5-6 (2013).

⁶⁷ CAT Committee, *Concluding Observations: Peru*, para. 15(b), U.N. Doc. CAT/C/PER/CO/5-6 (2013).

⁶⁸ Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 47, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan Méndez).

bleeding” and ‘excessive sexual desires.’” For adolescents and young women, lack of youth and adolescent friendly services meant that they could not access services at the main health facilities.

This is exacerbated by lack of formal and comprehensive sexuality education (CSE), stigma on adolescent SRHR, lack of implementation of policies, and restrictive legislative frameworks. For instance, one of the key objectives of the National Adolescent Sexual and Reproductive Health Policy is to contribute to increased access to adolescent sexual and reproductive health information and age-appropriate comprehensive sexuality education. Kenya has also signed on to the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013). Despite this framework, Kenya is yet to implement a comprehensive sexuality curriculum. This is due to increased opposition specifically from religious organizations and misconceptions about CSE. Subsequently teenage pregnancies have been on the rise leading to increased school dropouts. According to the 2014 DHS, about 20% of girls between the ages of 15-19 in Kenya have had at least one child. Adolescent girls from lower income levels are more likely to have begun childbearing than their wealthier counterparts, as are adolescents who do not complete primary or secondary school.

Women and girls with disabilities face multiple challenges and discrimination while seeking family planning services and information. For instance, CRR-TICAH baseline survey established that women and girls with disabilities rarely sought reproductive health services in health facilities. This is mainly due to stigma, informed by the perception that they do not have sexual desire and therefore do not take part in sexual relations, and as such they would need to protect themselves from infections or prevent pregnancies. Further lack of information in accessible formats hinders women and adolescents with disabilities from seeking family planning services. For instance, during the study, it was established in several health facilities information is usually disseminated in print form. Most public health facilities reported that they lacked alternative modes of communication such as sign language, plain language for people with intellectual disabilities and audio messages for the visually impaired.

E. Criminalization of Noncoercive and Nonexploitative Sexual Conduct Among Adolescents

Ensuring all adolescents have access to the full range of sexual and reproductive health services is a critical component of ensuring freedom from all forms of violence and cruel, inhuman and degrading treatment. For instance, access to comprehensive and accurate sexual and reproductive health information is fundamental to ensuring that adolescents are well informed and can make decisions about their sexual life thus preventing unwanted pregnancies, and sexually transmitted infections, including the transmission of HIV. The Committee has urged states to ensure adolescents access to sexual and reproductive health services in order to prevent unwanted pregnancy.⁶⁹ However, criminalization of noncoercive and nonexploitative sexual conduct amongst adolescents results in denial of legally recognized services such as safe and legal abortion for victims of sexual violence, and fuels stigma which may result in emotional and psychological suffering amounting to torture or CIDT.

The lack of clarity between the law and adolescent sexual and reproductive health policy has caused confusion on provision of adolescent sexual and reproductive health services (ASRH) and fuelled stigma around ASRH. The implication of this is adolescents being denied essential ASRH services or being criminalized for developmental behaviour such as engagement in non-coercive sexual conduct. This results in emotional suffering among adolescents who end up engaging in risky behaviours due to the disabling environment.

⁶⁹ CAT Committee, Concluding Observation: Sierra Leone, para. 17, U.N. Doc. CAT/C/SLE/CO/1 (2014); see also El Salvador, para. 23, U.N. Doc. CAT/C/SLV/CO/2 (2009); Peru, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006)

For instance, the Sexual Offences Act 2006 (SOA) does not make any distinction between sex between adolescent minors and sexual acts between adolescent minors and adults — all of which are classified and/or have been interpreted as criminal offences.⁷⁰ The SOA also does not make any distinction between noncoercive and nonexploitative and coercive and exploitative sexual conduct between minors.⁷¹ The SOA therefore criminalizes noncoercive and nonexploitative sexual conduct among adolescents. Consequently, adolescent males have been imprisoned and, in some cases, have ended up with a permanent criminal record for engaging in non-coercive sexual conduct with other adolescents. The implication is adolescents suffering for engaging in developmental activities and a record that adversely affects their future which is against the best interest of the child. In extreme cases, some adolescents have been locked up in adults' prisons which exacerbates their suffering. For instance, the case of DOB.

In 2018, DOB was a 16- year-old Form Three student living in a village in the Western part of Kenya. He had a 14-year-old- girlfriend- YB, also from the same village. The fact of their relationship was well known to their neighbours, parents and relatives. According to DOB and his mother, both minors had several sexual encounters with each other. In the same year, DOB was accused of defiling YB by her grandmother. He was arrested, charged and sentenced to serve 20 years in prison—the maximum penalty. Despite being a minor, he was processed as an adult because court records erroneously indicated that he was 19 years at the time of commission of the offence. His birth certificate, however, shows that he was 17 years old. Nobody ascertained his age during the entire trial. DOB is serving time in Kodiaga Prison, one of the toughest prisons in the country for an egregious procedural omission.⁷²

F. QUESTIONS

- i. What measures is the government undertaking to ensure that women have access to safe and legal abortion and post-abortion services. Specifically, what measures has the Kenyan government established to implement the court decision reinstating the Standard and Guidelines on Reducing Maternal Morbidity and Mortality due to unsafe abortion?
- ii. What concrete measures is the government taking to eliminate abuse and mistreatment of women seeking maternal health services by medical and hospital staff?
- iii. What measures is the government taking to ensure that women and girls seeking maternal health services are not detained in hospitals post-delivery or are not denied services due to inability to pay?
- iv. What measures does the government plan to undertake to remove the barrier women and girls face in accessing contraceptive services including by ensuring that they have access to comprehensive reproductive health information and services?
- v. What concrete measures is the government taking to investigate and prosecute perpetrators of sexual and reproductive rights violations against women and girls during the 2007-2008 post-election violence and 2017 elections, including effective mechanisms for accountability and redress?

⁷⁰ Center for Reproductive Rights & Federation of Women Lawyers, *Criminalizing Adolescence: A Call to Reform the Sexual Offences Act* (2019) available at <https://reproductiverights.org/sites/default/files/documents/Designed%20Long%20Version%20of%20Briefing%20Paper%20on%20Adolescent%20SRHR-Covers1.pdf>

⁷¹ *Id.*

⁷² Interviews with DOB, his mother and neighbors undertaken in July 2019, *on file with the Center for Reproductive Rights*

- vi. What concrete measures is the government taking to ensure that adolescents are not criminalized for non-coercive sexual conduct and that they do not end up with permanent criminal records?

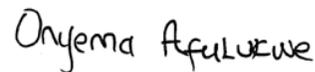
G. RECOMMENDATIONS

- I. The Kenyan government should end detention of women post-delivery due to their inability to pay medical bills.
- II. The government should make available in all facilities trained health professionals, essential medicines and equipment for safe and legal abortion in accordance with the Constitution of Kenya and the High Court of Kenya judgement on Petition 266 of 2015.
- III. The government must end the mistreatment and abuse experienced by women while seeking maternal health services, hold those who violate their rights accountable, and establish and strengthen complaints mechanisms within facilities to allow reporting of mistreatment while seeking maternal health services.
- IV. The Kenyan government must ensure access to dignified and quality care by women seeking maternal health services. Such measures should include training of health professionals on patients' human rights and ensuring that facilities adopt a rights-based approach to delivery of maternal health services.
- V. The government should amend the Sexual Offences Act (2006) by decriminalizing noncoercive and nonexploitative sexual conduct among adolescent minors.
- VI. The government should ensure access to comprehensive sexuality education and sexual and reproductive health information and services for adolescent girls and women, including in accessible formats and language.
- VII. The Kenyan government should investigate and prosecute perpetrators of sexual violence against women and girls during 2007-2008 post-election violence and the 2017 elections.
- VIII. The government should put in place measures to ensure that women and girls in crisis-affected parts of Kenya, especially during election periods, have access to the full range of sexual and reproductive health services. Specifically, the government should map out all hot spots areas ahead of elections and ensure that sexual and reproductive health services are part of its planning.

We hope that this information is useful during the Committee's review of government of Kenya. If you would like further information, please do not hesitate to contact the undersigned.



Evelyne Opondo
Senior Regional Director for Africa
Center for Reproductive Rights



Onyema Afulukwe
Senior Counsel for Africa
Center for Reproductive Rights