



Committee on the Elimination of Discrimination against Women

Human Rights Treaties Division

Office of the United Nations High Commission for Human Rights

Palais Wilson – 52, rue des Pâquis

CH-1201 Geneva, Switzerland

September 22, 2017

Re: Supplementary information on Kenya scheduled for review by the Committee on the Elimination of Discrimination against Women during its 68th Session

Distinguished Committee Members,

The Center for Reproductive Rights (the Center)¹ and the Federation of Women Lawyers – Kenya (FIDA)² hope to further the work of the Committee on the Elimination of all Forms of Discrimination against Women (the Committee) by providing independent information on Kenya, scheduled to be reviewed during the Committee’s 68th session. This letter is intended to supplement the eighth Periodic Report of the government of Kenya. It is also intended to supplement the Center’s pre-session letter of February 20, 2017 addressed to the Committee. The letter addresses: the high rate of preventable maternal mortality and morbidity; detention, abuse and mistreatment of women seeking maternal health care services; inaccessibility of safe abortion services and post-abortion care; lack of access to comprehensive family planning services and information; and gender-based violence, including female genital mutilation.

A. High Incidences of Preventable Maternal Mortality and Morbidity

Several treaty-monitoring bodies (TMBs), have framed the issue of maternal mortality as a violation of women’s rights to health and life.³ In its 2007 Concluding Comments to Kenya, the Committee recommended that the **government of Kenya step up its efforts to reduce the incidence of maternal and infant mortality... and increase women’s access to health-care facilities and medical assistance by trained personnel, especially in rural areas.**⁴ In its 2011 Concluding Observations to Kenya, the Committee expressed its concern about the increasing maternal mortality rate (MMR) and made a similar recommendation.⁵

In its most recent List of Issues (LOIs), the Committee asked the government of Kenya to “provide information on the specific measures being taken: (a) to address the high maternal mortality rate, which is attributable to a lack of skilled birth attendants ...”⁶, to “state the specific measures in place to address: (a) the limited access to antenatal care, delivery and postnatal care,”⁷ and to “(d) address regional disparities in access to health-care services, in particular for women and girls.”⁸ In response, the government of Kenya notes that “Measures are being taken to address the high maternal mortality rate in Kenya through the free maternity care policy which was instituted in 2013”, and that “Regional disparities in access to health care services [have been addressed] through the provision of ambulances at county level.”⁹

However, despite these efforts, Kenya's MMR remains high. The World Health Organization's (WHO) 2015 report found that the MMR had only decreased by 1.2% per year since 1990.¹⁰ According to the same report, out of every 100,000 live births, 510 Kenyan women and girls die,¹¹ which is an increase from the MMR documented in the same WHO report covering previous years.¹² According to the 2014 Kenya Demographic Health Survey report (2014 KDHS),

The maternal mortality ratio was 362 maternal deaths per 100,000 live births for the seven-year period preceding the survey. When comparing the estimate of an MMR of 362 with the MMR estimated in the previous KDHS (2008-09 KDHS estimate of 520 maternal deaths per 100,000 live births), the differential is not large enough to conclude whether or not there has been any change over time between the two surveys.¹³

Part of this trend can be attributed to the significant challenges low-income women, women with lower levels of education, and those in rural areas, encounter in accessing quality maternal health care services. According to the 2014 KDHS, only 58% of pregnant women attended the WHO recommended four or more antenatal care visits.¹⁴ A woman's geographic location has a significant impact on her access to antenatal care: 68% of women living in urban areas are more likely to attend four or more antenatal care visits compared to 51% of those living in rural areas.¹⁵ Women with higher education and those in a higher wealth quintile are also more likely to attend the recommended antenatal care visits than their counterparts.¹⁶ A more recent study of 564 facilities across Kenya offering at least one maternal care service found that the quality of maternal care is low, especially for antenatal and delivery services.¹⁷ In addition, hospitals have reported not having tools that capture data on expectant women with disabilities; the lack of information on these women's particular needs has led to the failure to provide them with maternal health services that are adapted for them.¹⁸ Moreover strikes by doctors and nurses, including one that has been ongoing since December 2016, lead to a general disruption of health services including leaving maternity services barely functioning.¹⁹

Free maternity services were introduced in 2013 through a Presidential Directive²⁰ but implementation of the Directive remains problematic. Women continue to face challenges in obtaining quality delivery care; and access to skilled providers during delivery is markedly worse for lower income, less educated, and rural women.²¹ The 2014 KDHS Summary notes that only about 50% of rural women versus 82% of urban women obtain delivery assistance from a skilled provider such as a doctor, nurse, or midwife.²² Similarly, the wealthiest women are four times more likely to deliver under the care of a skilled attendant at a health facility.²³ 17% of all women in the abovementioned study were found to have access to minimally adequate delivery care against 8% of poor women.²⁴ Further, while the WHO recommends postnatal care starting an hour after giving birth for the first 24 hours in order to check for complications,²⁵ only 51% of women receive a postnatal checkup within two days of giving birth.²⁶

It is commendable that in January 2014, the First Lady of Kenya spearheaded the Beyond Zero Campaign (a private initiative financed by the public and development partners) to raise awareness about the link between good health and a strong nation, specifically demonstrating the importance of maternal, newborn, and children's health.²⁷ The Campaign has delivered forty-seven mobile clinics since its inception.²⁸

In the current LOIs, the Committee asks the government to "state the specific measures in place to address: (c) the scaling-up of the "Beyond Zero" campaign..."²⁹ The government, while stating the achievements of the campaign,³⁰ did not provide specific information on the scaling up thereof.

The First Lady has however stated, "[the] initiative alone cannot bring about success. Success requires all actors in the health sector especially county governments to expand this program to every corner" of Kenya.³¹ The initiative needs to be fully owned by the government and public service to ensure its continuity beyond the time during which the first lady holds her office. The high MMR shows that the government needs to scale up its efforts to ensure all pregnant women, including women in vulnerable situations, such

as those with disabilities, in rural areas, and those with low incomes, have access to comprehensive maternal health services.

Inadequate implementation of presidential directive on free maternity care for all pregnant mothers at public health facilities

As noted above, the government issued a Presidential Directive in June 2013, which provided that all pregnant women would be able to “access free maternity services in all public health facilities.”³² In the last quarter of 2016, the free maternal health directive was expanded to include 700 faith-based health facilities and 2000 private health facilities.³³ According to the Kenya National Commission on Human Rights (KNCHR), hospital infrastructure and staffing have not been able to support the additional number of women who came seeking free maternal health care following the initial declaration,³⁴ and the government failed to allocate sufficient additional resources to remedy this issue.³⁵ Furthermore, there have been no clear guidelines set by the government about how to implement the free maternal services directive; neither is it clear whether the Directive is articulated in a policy, complete with a plan for its implementation. Although some facilities were reportedly given extra money to cover the influx of deliveries, others have remained uncertain of how to balance the new policy of free care with their need to cover costs.³⁶

Despite the Directive, women still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.³⁷ Other key components of maternal health services, including antenatal and postnatal care, are also not covered under the Directive.³⁸ Further, the Reproductive Healthcare Bill that was debated in the Senate in 2016 provides for free antenatal care,³⁹ but does not offer any further clarity regarding implementation of the Directive. It remains uncertain if the Bill will be picked up for further debate and development by the new Senate, now in place following the August 2017 General Elections.

Detention, abuse and neglect of women seeking maternal health services in health care facilities

The Committee during its review of Kenya in 2011 recommended that the government, “...increase women’s access to health care facilities and medical assistance by trained personnel...”⁴⁰ However, a fact-finding report conducted by the Center and FIDA, revealed that women who attend maternal health care services are frequently neglected and encounter systematic abuse from health care professionals and staff.⁴¹ Women in vulnerable situations such as those with disabilities have reported harassment from nurses in labor wards including those with hearing impairments being harassed due to not adhering to instructions that they were being given although they could not hear.⁴²

Women with low income have also experienced abuse and detention. At a focus group discussion which the Center and the Kenya Network of Grassroots Associations organized in 2012, 23 of the 26 women who participated in the discussion, stated that they were detained after giving birth for not paying their bills at Pumwani Maternity Hospital (Pumwani), which is the largest maternity hospital in Kenya.⁴³ Most of the women were detained for durations of between two weeks and two months.⁴⁴ The majority of them also reported that they were not released until after someone paid the hospital fees on their behalf or advocacy groups intervened and that they were denied postnatal and other crucial medical care.⁴⁵ Violations including abuse and detention have continued.⁴⁶ In its most recent Concluding Observations on Kenya, the Committee against Torture (CAT Committee) noted its concern about “the ongoing practice of post-delivery detention of women unable to pay their medical bills, including in private health facilities.”⁴⁷

In response to these egregious actions, the Center filed a case on behalf of two women in the High Court of Kenya in 2012 highlighting the abuse women face at health care facilities and seeking declaration that this treatment amounts to a violation of their human rights.⁴⁸ On September 17, 2015, the Court made a declaration that the rights of the petitioners, including their right to health, liberty and dignity, had been violated by their detention and other actions of the health care professionals at Pumwani and that they were

discriminated against based on their socio-economic status. The Court ordered the government to pay monetary compensation to the petitioners for the damages they suffered as a result of these violations. The government lodged an appeal against the judgement but did not prosecute it and it therefore stands as an order that should be implemented. The amounts ordered in damages are being processed for payment by the relevant County Departments and the Ministry of Health, through the head of its Reproductive Health Unit has recognized the Judgement as the law of Kenya and expressed willingness to facilitate its implementation.⁴⁹

Further, in a bid to emphasize the need to end abuse of women during delivery, in 2014 the Centre filed another suit in Bungoma High Court; the petitioner in the case was neglected and abused by the staff of the hospital in Bungoma, which she was attending for delivery. She was not monitored while in labor and, when she was unable to find a free bed in the delivery ward, she collapsed unconscious on the floor, where she gave birth. When she subsequently regained consciousness, two nurses were slapping her face and shouting at her for dirtying the hospital floor during delivery.⁵⁰ The case will be heard in October, 2017.

Even the declaration of free services has not fully addressed the unlawful detention of women nor the issue of abuse and mistreatment of women that attend maternal health facilities; in fact, the situation may have worsened as health care staff attempt to cope with an influx of delivery patients.⁵¹ In June 2017, the media published a story about Doris, a woman who had been detained in a hospital in Kiambu town for more than six months after complications following the birth of her son saw her hospital bill soar to an amount which she could not afford to pay.⁵² Another story of four mothers locked in a basement in a hospital in Embu along with their newborns, because they could not afford to clear their hospital bills, was published in January 2017.⁵³ These women, being denied meals at the hospital, had to rely on well-wishers for food.⁵⁴

The Committee, in its recent LOIs asked the government “to address...(b) the detention of mothers when they cannot pay their medical bills after delivery...”⁵⁵ The government responded that “NHIF has expanded its range of products including contracted hospitals under three categories (A, B and C) to provide in patient medical cover with members enjoying full and comprehensive outpatient and inpatient services to cover maternity and medical diseases including surgery.”⁵⁶ This response, although addressing the government’s part in paying medical fees, does not raise specific actions being taken to address the fact that women continue to be detained in private as well as public health facilities.

There is evidently, still a need for the government to prioritize ending the detentions and rights violations by ensuring that women are no longer detained in maternal health facilities but rather receive quality and respectful maternal health care.

B. Lack of Access to Safe Abortion Services and Post-Abortion Care

A 2013 study conducted by the Ministry of Health estimated that nearly 465,000 abortions occurred in Kenya in 2012.⁵⁷ That same year, approximately 120,000 women sought care in health care facilities for unsafe abortion-related complications.⁵⁸ One study found that up to 60% of all gynecologic emergency hospital admissions are a result of complications from unsafe abortion.⁵⁹ In 2011, the Committee noted with concern that illegal abortion remains one of the leading causes of the high MMR and that Kenya’s restrictive abortion law further leads women to seek unsafe and illegal abortions.⁶⁰ The Committee urged the state to “[p]rovide women with access to good-quality services for the management of complications arising from unsafe abortions and to consider reviewing the law relating to abortion with a view to removing punitive provisions imposed on women who undergo abortion.”⁶¹ In 2013, the CAT committee recommended that the government “evaluate the effects of its restrictive legislation on abortion on women’s health with a view to regulating this area with sufficient clarity” and amend its laws to allow abortion on the grounds of rape and incest.⁶² More recently, the Committee on Economic Social and Cultural Rights recommended that the government “amend its legislation on the prohibition of abortion in order to render it compatible with other

fundamental rights, such as women’s rights to health, life and dignity, and reinstate the Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya.”⁶³ The same was echoed during the Universal Periodic Review process in 2015, when it was recommended that Kenya “Ensure that women have access to legal and safe abortions, especially in cases of pregnancies resulting from rape or incest.”⁶⁴

In the current LOIs, the Committee asks the government to “provide information on the specific measures being taken: (a) to address the high maternal mortality rate, which is attributable to...unsafe abortion practices”⁶⁵ and “(c) to revise articles 158 to 160, 228 and 240 of the Penal Code in order to decriminalize abortion in all cases and legalize abortion in cases of rape, incest and severe fetal impairment.”⁶⁶ The government does not provide any such information in its response to the LOIs.

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,⁶⁷ the Penal Code has not been revised to reflect this change.⁶⁸ Therefore, a woman could still face prosecution for seeking an abortion in circumstances allowed under the Constitution.⁶⁹ Before its revision in 2014, the 2004 *National Guidelines on the Medical Management of Rape and Sexual Violence* provided that “[t]ermination of pregnancy is allowed in Kenya after rape.”⁷⁰ Even though this statement was removed from the main text of the guideline during its revision in 2014, the new guideline still provides, in its annex, that survivors of sexual violence have the right to “[a]ccess termination of pregnancy and post-abortion care in the event of pregnancy from rape.”⁷¹ Yet, neither the Constitution nor the Penal Code have expressly provide for this exception. The Committee Against Torture, expressed concern that there is no right to abortion (at minimum) in cases of rape, a consequence of which is women left in an unjustified situation with “grave repercussions on their health.”⁷²

The Ministry of Health 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.⁷³ In addition, in 2014, the Ministry of Health issued a memo to all health care providers stating that “abortion on demand is illegal” without clarifying the legal exception under the Constitution.⁷⁴ 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.⁷⁵ 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.

This lack of clarity in the legal framework and restrictions on safe abortion services result in women and girls resorting to clandestine abortions, which are often unsafe and subject women to grave pain and suffering. The harshness of Kenya’s abortion laws most heavily impacts young women⁷⁶—for whom the unintended pregnancy rate is highest⁷⁷—even where relatively safe abortion procedures are available, because the cost of these services often exceeds these women’s financial resources.⁷⁸

In June 2015, the Center and FIDA filed a case in the High Court of Kenya at Nairobi that challenged the Ministry of Health’s memo and the withdrawal of the Standards and Guidelines. The 1st Petitioner, on whose behalf her guardian is suing the State, is a girl who underwent an unsafe abortion, was unable to access post- abortion care and suffered physical and emotional harm. The objective of the case is 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 persons mandated to undertake abortions are able to be trained in order to know how to carry out safe abortions. A bench of 5 judges was constituted and all preliminary issues have been dispensed with. The case has been set down for hearing in October, 2017.

Post-abortion care

Access to post-abortion care (PAC) is essential to protect the health and lives of women following an unsafe abortion—particularly in Kenya where the rate of unsafe abortion and resulting complications remain high. For example, a hospital in Mombasa received at least 102 patients in need of PAC during a four-month period from late 2014 to early 2015.⁷⁹ Moreover, a 2015 study found that 77% of Kenyan women seeking PAC suffered from moderate or severe complications.⁸⁰ However, barriers to access to PAC create delays in receiving essential treatment, which cause disproportionately higher rates of severe post-abortion complications.⁸¹

Reports by the KNCHR, FIDA and the Center have revealed that women often delay seeking PAC due to fear of the social stigma and legal risks associated with abortion, including harassment by the police and possible prosecution.⁸² Although the government has stated that PAC “is legal and not punishable by any part of Kenya [*sic*] laws,”⁸³ this declaration only offers protection to the health care providers and not to women who seek PAC.⁸⁴ Further, delays in arriving at the health care facility and obtaining the right treatment are endemic in Kenya as a result of “shortages in staffing, equipment, drugs, and poor attitude of health care providers.”⁸⁵ These delays can have fatal consequences for women that present with treatable conditions.⁸⁶ Studies indicate that medical personnel—particularly nurses—are inadequately trained, so that women suffering from complications may have to wait an extended period of time for a trained provider to attend to their medical needs.⁸⁷

C. Lack of Access to Family Planning Information and Services

In its 2011 Concluding Observations, the Committee urged Kenya to “[s]trengthen and expand efforts to increase knowledge of and access to affordable contraceptive methods throughout the country and ensure that women in rural areas do not face barriers to accessing family planning information and services.”⁸⁸ Kenya also received a recommendation to “intensify its efforts to improve health infrastructure as well as the quality and delivery of health services, including...contraceptives for women in marginalized areas.”⁸⁹ However, according to a 2016 study, less than half of Kenyan women (44.2%) are able to access modern methods of contraceptives.⁹⁰ As of 2008, the contraceptive use among women living with disabilities was 16%, still considerably lower than the then national average, that was not much different from the current national average for contraceptive use.⁹¹

A large portion of Kenyan women have an unmet family planning need, which is defined as women who would like to delay their next birth by at least two years or would like to cease childbearing, but are not currently using a contraceptive method.⁹² Although women from all demographic backgrounds have significant unmet family planning needs,⁹³ 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.⁹⁴ In addition, usage disparities are even more pronounced by geographic area⁹⁵ due to factors including inequitable regional distribution of contraception and frequent stock outs. For example, only 3.4% of women in the former Northeastern Province—a region with low socio-economic indicators—⁹⁶ use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.⁹⁷

These disparities in usage rates are due to a variety of barriers to women’s and adolescents’ access to family planning information and services. Physical barriers to accessing contraceptives include public health facility stock outs, inequitable distribution throughout the country, and costs associated with procuring contraceptives, such as lost wages or transportation.⁹⁸ Despite the Ministry of Health’s 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.⁹⁹ Moreover, a woman’s preferred method of contraception is often unavailable¹⁰⁰ or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members.¹⁰¹ Examples

include perceptions of young women who carry condoms as promiscuous, “sexually wayward,” or “untrustworthy”; women’s husbands becoming angry when their wives begin using contraceptives; or unmarried women feeling ashamed to obtain contraceptives.¹⁰² Another example is stigma against women with disabilities, informed by the perception that they do not have sexual desire and therefore do not take part in sexual relations, related to which they would need to protect themselves from infections or prevent pregnancies.¹⁰³ They are regularly deprived of control over their reproductive health, including decisions making on family planning, also on the assumption that they are incapable of consenting to sex.¹⁰⁴

In its latest report, the government acknowledges that HIV/AIDS still poses one of the greatest challenges in Kenya and further that HIV prevalence is highest among women.¹⁰⁵ The Committee in its LOIs to Kenya asked the government to “provide information on the specific measures being taken: ... (b) to intensify the provision of contraceptives in order to combat HIV transmission...”¹⁰⁶ The government does not provide a response to this request in its response to the LOIs.

In its 2011 Concluding Observations, the Committee urged the government to “[w]idely promote education on sexual and reproductive health and rights targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of STIs, including HIV/AIDS.”¹⁰⁷ However, the government has not provided information about the steps it is taking to increase adolescents’ access to reproductive health information. Research shows that social stigma against the use of contraception is particularly problematic for adolescents, who are one of the groups most vulnerable to experiencing discrimination in access to family planning services.¹⁰⁸ Research also shows much higher lack of approval for and objection to unmarried adolescents using contraception than for married adolescents.¹⁰⁹

Young people in Kenya also lack formal and comprehensive sex education.¹¹⁰ On this subject, the Committee, in its most recent LOIs to Kenya asks the government to “provide information about whether an age-appropriate education programme on sexual and reproductive health and rights for all levels of education has been integrated into curricula...”¹¹¹ The government does not provide a response to this request either. The lack of comprehensive sex education results in misinformation about young people’s reproductive health, including concerns about poor outcomes from using contraceptives.¹¹² These misconceptions lead to lower contraceptive use rates and a higher incidence of unplanned and unwanted pregnancies.¹¹³

Access to emergency contraception

Women’s access to emergency contraception (EC) is an essential component of the full range of contraceptive options that women must have—particularly for survivors of sexual assault and following unprotected sex.¹¹⁴ Many women and girls could prevent unplanned or unwanted pregnancies by using EC, a safe and effective method that can be used within 120 hours of unprotected sex and a critical component of care for survivors of sexual violence.¹¹⁵ Indeed, the National Guidelines on the Management of Sexual Violence in Kenya requires that EC be available 24 hours a day for survivors of sexual violence in all health facilities, free of charge.¹¹⁶ In Kenya, ten products of EC are registered,¹¹⁷ and the Ministry of Health broadly recommends its use for those “who have had unprotected sexual intercourse and desire to prevent pregnancy.”¹¹⁸ The Ministry also has recognized that EC “is an important component of adolescent reproductive health.”¹¹⁹ In addition, it is included in Kenya’s essential drugs list and the *National Family Planning Guidelines for Service Providers*, which stipulates that EC should be provided without restriction.¹²⁰

There are significant barriers to accessing EC. Consistent stock outs in pharmacies and shipment delays prevent women and girls from reliably accessing the medicine.¹²¹ Some pharmacists also decline to distribute EC altogether or refuse to dispense it without a prescription,¹²² although EC is registered in Kenya as an over-the-counter medicine.¹²³ Despite the Ministry of Health’s guidelines that explicitly permit EC’s usage for any unprotected sex, arbitrary refusals stem from the perception that the contraceptive is only

intended to be used by rape victims.¹²⁴ Moreover, adolescents are routinely denied access to EC for arbitrary or discriminatory reasons such as “the person looks young.”¹²⁵ A 2014 study found that only 18% of women and girls surveyed in Nairobi have ever used EC.¹²⁶ Private health care facilities may not always offer EC either. For example, although facilities run by the Catholic Church or Christian Health Association of Kenya provide services to survivors of sexual violence, they do not provide EC to these individuals.¹²⁷

D. Discrimination Resulting in Gender-Based Violence and Harmful Traditional Practices Against Women and Girls

Gender-based violence has been addressed in many of the Concluding Observations to Kenya issued by various TMBs. The Kenyan government noted in its Periodic Report that it has passed and introduced various initiatives to address issues of gender-based violence, including the National Policy on Prevention and Response to Gender Based Violence, Protection against Domestic Violence Act, and Gender Based Violence Recovery centers in the largest public hospitals.¹²⁸ However, the government also acknowledges that a number of initiatives remain pending including the National Policy Framework and Guidelines for the Administration of Sexual Violence and the National Guidelines on Rape and Sexual Violence Management.¹²⁹ The government further acknowledges, “Weak medico-legal linkages: medical (such as care and treatment) and legal (such as a survivor’s access to justice) responses to GBV in order to guarantee survivor safety, effective prosecution of cases and uphold perpetrator rights to a fair trial. Kenya currently lacks a harmonized chain of custody of evidence across the medical, police and legal levels that ensures the plausibility of cases in court.”¹³⁰ As a result, significant gaps remain in the legal and policy framework to address violence against women and girls; the government must do more to effectively implement the existing legal protections and ensure access to services for survivors of gender-based violence.

Sexual and Domestic Violence against Women and Girls

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,¹³¹ which is not a significant decrease from 2008-2009 KDHS which showed that 47% of ever-married women reported having experienced such violence.¹³² 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.¹³³ Women in vulnerable situations may face higher risks of experiencing sexual and physical violence. For instance, for women with disabilities, the multiple and intersecting forms of discrimination based on their gender and disabilities increase their vulnerability to gender-based violence.¹³⁴ They are three times as likely to experience sexual and gender based violence as their counterparts who have no disabilities.¹³⁵

In May 2015, the President signed into law the Protection against Domestic Violence Act¹³⁶ 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.¹³⁷ It also sets out protection mechanisms for victims, such as counseling and medical assistance, as well as protection orders against the perpetrator.¹³⁸ Prior to that, the Victim Protection Act¹³⁹ 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.¹⁴⁰

During Kenya’s 2015 review in the UPR process, it was recommended that the government “Eliminate stereotypes and harmful practices against women (including FGM, wife inheritance, [and] forced and early marriage.”¹⁴¹ Prior to that in 2011, the CEDAW Committee, taking stock of violence and harmful practices impacting on the lives of girls and women in Kenya recommended that the government implement the Children’s Act, 2001 and adopt regulations that will inform implementation of the Sexual Offences Act, 2006, including protection of children from violence.¹⁴²

In the current LOIs, the Committee asks the government to provide “an update on the practical measures taken by the State party, through the coordination role of the Board, to eliminate the harmful practice of female genital mutilation in all regions of [Kenya]”¹⁴³ and “information on steps taken to investigate, prosecute and punish perpetrators of sexual and gender-based violence...”¹⁴⁴ In response, the government provides that there is “Enforcement of the Prohibition of Female Genital Mutilation Act (Chapter 62B of the Laws of Kenya). Certain individuals contravening the law have been prosecuted.”¹⁴⁵ The government adds that “There have been steps taken to implement support services for victims of Gender based violence, through the establishment of one-stop shops at referral hospitals, and within some police stations there are gender desks. These have been used to report cases of GBV.”¹⁴⁶ In addition, that a “Gender based violence hotline (Dial 1195) was established and launched in March 2017.”¹⁴⁷

To address the prevalent violence however, the government needs to take concrete steps to ensure the full and effective implementation of the Protection against Domestic Violence Act. This is particularly important since survivors of sexual and physical violence often and face a number of barriers that prevent them from receiving meaningful assistance from medical or legal professionals.

Sexual violence against girls and adolescents, particularly in educational settings

In the current LOIs, the Committee asks the government to “provide an update on the status of measures to combat the abuse of learners, in particular women and girls, by teachers, such as: (a) the development of a learners’ protection policy to protect girls from being impregnated by their teachers; ...including the protection of girls from all forms of violence, including sexual harassment at school.”¹⁴⁸ The government responds that “The Teachers Service Act 2012 protects learners from abuse through the Teacher Service Commission denying registration of teachers who have committed an offence against a learner or those who have been convicted of a sexual offence committed against a learner.”¹⁴⁹

Violence and abuse against adolescents and girls is a pervasive problem in Kenya, with an even higher prevalence than statistics suggest due to underreporting. Recent survey results show that one in three Kenyan girls experience some form of sexual violence before the age of 18.¹⁵⁰ A household survey of more than 3,000 young people aged 13 to 24 years revealed that three out of four had experienced physical, sexual, or emotional violence.¹⁵¹ Of those who had experienced violence, six out of ten have been physically abused.¹⁵² Rape is rarely reported as a result of pervasive social stigma and a deep mistrust in police and the criminal justice system.¹⁵³ A 2012 UNICEF study determined that only about 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.¹⁵⁴

Sexual violence against girls and adolescents is also a significant problem in schools and other educational settings. According to the same UNICEF study, from the women aged 18 to 24 who experienced unwanted sexual touching before the age of 18, about 25% reported that the first incident took place in school.¹⁵⁵ A 2009 report by the Kenya Teachers Service Commission (TSC) and the Centre for Rights Education and Awareness estimated that 12,660 girls were sexually abused by their teachers in Kenya between 2003 and 2007, although the report notes that 90% of sexual abuse cases go unreported.¹⁵⁶ Girls and women with disabilities are more vulnerable to sexual abuse. Many girls with disabilities, prone to sexual abuse fall pregnant and drop out of school before completing primary education.¹⁵⁷ As a result, most parents prefer that girls and women with disabilities stay at home than risk going to school because of the fear that they might be molested in schools, thereby impacting on their access to education.¹⁵⁸

There is still a high number of cases of girls being sexually assaulted by their teachers and care givers, girls subjected to Female Genital Mutilation and married off afterwards, without these perpetrators (teachers, caregivers, community leaders) being prosecuted and convicted. Since all of them live in the same community, this subjects these girls to stigma, affects their self-esteem and their will to go back to school, after being subjected to such practices.¹⁵⁹ A study that looked into the period between 2003 and 2009 found

that 12,660 girls were sexually abused by their teachers, but only 633 teachers were ultimately charged with sexual offences related to these abuses.¹⁶⁰

In *W.J. & Another v. Astarikoh Henry Amkoah & 9 Others*, a case in which the Center submitted an amicus brief, two adolescent girls were sexually abused by the Deputy Head teacher at Jamhuri Primary School in Nakuru County, Kenya.¹⁶¹ In a decision rendered in 2015, the High Court of Kenya not only found the teacher civilly liable for sexual assault, but also determined that the government and TSC handled the case inadequately. The Court ordered the government to provide financial reparations to the two girls and the TSC to update its guidelines to better handle sexual assault allegations.¹⁶² Although the TSC circular, or employee guidelines, mentions disciplinary action for the sexual assault of students,¹⁶³ the circular fails to indicate clear mechanisms for disciplinary action or provide for sexual assault survivors to receive psychological or essential health care.¹⁶⁴ It is notable, however, that TSC has appealed this decision challenging the findings on vicarious liability and that its obligations to children who have suffered sexual abuse in schools extend to preventive, protective and remedial measures, including victim care, compensation and rehabilitation.

RECOMMENDATIONS

Maternal Health

The government of Kenya should provide access by all women, including those of low incomes and those in rural areas, to quality antenatal, postnatal and delivery services by skilled health personnel and provide access to post-abortion care services to any woman or girl presenting with complications from an unsafe abortion.

The government should, in line with CEDAW Committee's General Recommendation No.18,¹⁶⁵ collect information on the maternal health needs of expectant women with disabilities and take special measures, including adapting maternal health services for them in accordance with the needs identified, in order to ensure that they have equal access thereto.

The government should clarify whether the Presidential Directive on free maternal care is anchored in policy. It should take steps to effectively implement the Directive, including by providing guidelines on how the directive should be implemented and clear mechanisms of disbursing funds to and reimbursing health facilities in a timely manner, equipping hospitals and increasing staff capacities in order for the health facilities to be able to appropriately attend to the increasing number of women seeking maternity services.

The national and county governments should take action to stop ongoing and impending health workers' (doctors and nurses) strikes and to avoid the maternal deaths that occur during such strikes.

The government must emphasize the dignified treatment of women seeking maternal health services, including by ensuring that no women are detained after receiving maternal care, taking legal and/or administrative action against all health facilities that detain women due to their inability to pay hospital bills, training health service providers such as nurses and hospital managers on patients' human rights, and ensuring that facilities adopt a rights based approach to delivery of maternal health services.

Unsafe Abortion and Lack of Access to Post-Abortion Care

The government should decriminalize abortion including by repealing Kenya's Penal Code clauses that criminalize the same. It should also review the law on abortion to bring it in line with international and regional human rights standards as well as implement such law to provide access to comprehensive abortion care and post-abortion care services to all women. The government should also reinstate the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya*.

Access to Family Planning Information and Services

The government should take steps to ensure that women and adolescent girls, including those in rural areas, those of low income, and those with disabilities have access to comprehensive information on the full range of family planning and contraceptives and that they also have access to affordable family planning and contraceptive services including emergency contraceptives.

Physical and Sexual Violence Against Women and Girls

The government should take concrete actions to eliminate and protect girls from female genital mutilation including by ensuring that the Prohibition of Female Genital Mutilation Act is implemented, that the Board established thereby is fully functioning and by raising awareness of the harmful nature of the practice among communities and their leaders, in areas where it is prevalent.

The government should take concrete actions to address violence against women and girls, including women and girls with disabilities, in school settings, including by ensuring: that provisions in the Protection against Domestic Violence Act and the Victim Protection Act are implemented; that police officers are trained to handle domestic and sexual violence; that reporting procedures for sexual and gender based violence that women and girls can use without fear are set up; that allegations of violence are promptly processed and investigated; that perpetrators of violence against women and girls are prosecuted; and that the survivors of violence are offered protection, medical treatment, legal support, psychosocial/counselling support and compensation/reparations.

The government should ensure that the Teachers’ Service Commission holds teachers accountable for any sexual, physical or psychological abuse that they commit against students including by ending the practice of shuffling abusive teachers from one school to another, and dismissing teachers who are implicated in violence against students. The Government should also ensure that the affected students are afforded psychological and medical care.

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

Sincerely,

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- ¹ The Center for Reproductive Rights is a global organization, with headquarters in New York and regional offices in Nairobi, Kathmandu, Bogota, Geneva and Washington D.C. that uses the law to advance reproductive freedom as a fundamental human right that governments are obligated to respect, protect and fulfill.
- ² The Federation of Women Lawyers – Kenya is a non-profit, membership organization consisting of over 1,100 women lawyers committed to increasing women’s access to justice in both formal and informal justice systems in Kenya. It works to promote women’s individual and collective power to claim their rights in all sphere of life.
- ³ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Consideration of reports submitted by States parties under article 18 of the Convention, Initial report of Belize*, para. 56, U.N. Doc.A/54/38/Rev.1 (1999); *see, e.g., Fourth periodic report of Colombia*, para. 393; CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention, Combined second, third and fourth periodic reports of Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998); Committee on Economic Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].
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- ¹³⁵ UNFPA, *Sexual and Reproductive Health of Persons with Disabilities*, 6 (2009), available at https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf.
- ¹³⁶ *Kenya: Uhuru Signs Domestic Violence Bill Into Law*, THE STAR, May 14, 2015 <http://allafrica.com/stories/201505150096.html>.
- ¹³⁷ See The Protection Against Domestic Violence Act (2015), KENYA GAZETTE SUPPLEMENT NO. 60 (ACTS NO. 2) (2015).
- ¹³⁸ *Id.*
- ¹³⁹ Victim Protection Act (2014), KENYA GAZETTE SUPPLEMENT NO. 143 (ACTS NO. 17).
- ¹⁴⁰ *A New Era for Victims of Crime in Kenya*, BOWRY & CO. ADVOCATES (Jan. 21, 2016), <http://bowrycoadv.com/a-new-era-for-victims-of-crime-in-kenya/>.
- ¹⁴¹ UPR Working Group Report 2015, *supra* note 64, para. 142.44.
- ¹⁴² CEDAW Committee, *Concluding Observations, Kenya*, paras 20 (a) and 22 (b) U.N. Doc. CEDAW/C/Ken/CO/7 (2011).
- ¹⁴³ CEDAW Committee, *List of Issues: Kenya 2017*, *supra* note 6, para. 8.
- ¹⁴⁴ *Id.* para. 10.
- ¹⁴⁵ CEDAW Committee, *Replies of Kenya 2017*, *supra* note 9, para. 29.
- ¹⁴⁶ *Id.* para. 32.
- ¹⁴⁷ *Id.* para. 34.
- ¹⁴⁸ CEDAW Committee, *List of issues: Kenya 2017*, *supra* note 6, para. 15.
- ¹⁴⁹ CEDAW Committee, *Replies of Kenya 2017*, *supra* note 9, para. 49.
- ¹⁵⁰ See Katy Migiro, *One Third of Kenyan Girls Subjected to Sexual Violence - Survey*, REUTERS (Nov. 28, 2012), <http://news.trust.org/item/?map=one-third-of-kenyan-girls-subjected-to-sexual-violence-survey> [hereinafter Migiro, *One third of Kenyan girls*]; UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA: FINDINGS FROM A 2010 NATIONAL SURVEY 2 (2010) available at https://www.unicef.org/esaro/VAC_in_Kenya.pdf [hereinafter UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA 2010].
- ¹⁵¹ This information was not disaggregated into male and female statistics. See Migiro, *One third of Kenyan girls*, *supra* note 150; see also UNICEF, HIDDEN IN PLAIN SIGHT: A STATISTICAL ANALYSIS OF VIOLENCE AGAINST CHILDREN 85 (2014) available at https://www.unicef.org/publications/index_74865.html.
- ¹⁵² *Id.*
- ¹⁵³ See Migiro, *One third of Kenyan girls*, *supra* note 150.

¹⁵⁴ Professional help includes assistance provided by institutions such as the police department, medical facilities, legal aid, religious groups and/or social services. Female victims, especially adolescents, are far more likely to seek assistance from their families or close friends. UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 150, at 129, fig.7.2.1.

¹⁵⁵ See *id.* at 51; see also Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION (Nov. 1, 2009), <http://allafrica.com/stories/200911020402.html>.

¹⁵⁶ UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 150, at 51.

¹⁵⁷ KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, FROM NORM TO PRACTICE, A STATUS REPORT ON IMPLEMENTATION OF THE RIGHTS OF PERSONS WITH DISABILITIES IN KENYA 10 (2014), *available at* <http://www.knchr.org/Portals/0/Reports/Disability%20Report.pdf>.

¹⁵⁸ MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY AND VSO, KENYA NATIONAL SPECIAL NEEDS EDUCATION SURVEY REPORT 58 (2014) *available at* https://www.vsointernational.org/sites/default/files/SNE%20Report_Full%20-2.pdf.

¹⁵⁹ See generally UNICEF, A STATISTICAL SNAPSHOT OF VIOLENCE AGAINST ADOLESCENT GIRLS (2014) *available at* https://www.unicef.org/publications/files/A_Statistical_Snapshot_of_Violence_Against_Adolescent_Girls.pdf

¹⁶⁰ Integrated Regional Information Networks (IRIN), *Analysis: Sex abuse in Kenyan schools* (May 30, 2011) http://www.ecoi.net/local_link/161054/264816_en.html (Accessed Sep. 15, 2017).

¹⁶¹ W.J. & Another v. Astarikoh Henry Amkoah & 9 Others, Judgment, Petition 311 of 2011 (2015) eKLR paras. 10, 14-15, 19-22 (High Ct. Kenya, Nairobi).

¹⁶² *Id.* paras. 111-12, 123.

¹⁶³ *Id.* paras. 123, 132-33, 150.

¹⁶⁴ See Brief for the Center for Reproductive Rights as Amicus Curiae Supporting Petitioners at 3, W.J. & Another v. Astarikoh Henry Amkoah & 9 Others, Petition 311 of 2011 (2015) eKLR (High Ct. Kenya, Nairobi), *available at* <http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/PETITION-331-OF-2011-CENTER-FOR-REPRODUCTIVE-RIGHTS-AMICUS-BRIEF.pdf>.

¹⁶⁵ CEDAW Committee, *General Recommendation No. 18: Disabled women*, (10th Sess., 1991), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).