CENTER FOR REPRODUCTIVE RIGHTS

Re: Supplementary Information on Kenya, Scheduled for Review by the Pre-sessional Working Group of the Committee on Economic, Social, and Cultural Rights during its 56th Session

Distinguished Committee Members,

This letter is intended to supplement the periodic report submitted by the government of Kenya, which is scheduled to be reviewed during the 56th pre-session of the Committee on Economic, Social and Cultural Rights (the Committee). The Center for Reproductive Rights (the Center) a global legal advocacy organization with headquarters in New York and, and regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C., hopes to further the work of the Committee by providing independent information concerning the rights protected under the International Covenant on Economic, Social and Cultural Rights (CESCR),[1] and other international and regional human rights instruments which Kenya has ratified.[2] The letter provides supplemental information on the following issues of concern regarding the sexual and reproductive rights of Kenyan women and girls: the high rate of preventable maternal mortality and morbidity; the abuse and mistreatment of women that attend maternal health care services; inaccessibility of safe abortion services and post-abortion care; lack of access to comprehensive family planning services and information; and discrimination resulting in gender-based violence and female genital mutilation.

I. The Right to Equality and Non-Discrimination

It has long been recognized that the obligation to ensure the rights to non-discrimination and substantive equality for all people underlies all human rights. Accordingly, states are required to address both de jure and de facto discrimination in private and public spheres.[3] They are further required to not only remove barriers but also take positive measures "to achieve the effective and equal empowerment of women."[4] To this end, they should "adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,"[5] develop policies that promote gender equality,[6] take efforts to eliminate gender stereotypes about women in the family and society,[7] and address practices that disproportionally impact women.[8] As the Committee noted, it is not sufficient for states just to guarantee women formal equality, as it does not adequately account for, and may even perpetuate, existing economic, social, and cultural inequalities between men and women.[9] Instead, states must ensure women substantive equality,[10] which seeks to remedy entrenched discrimination by addressing inequalities that women face. Similarly, it has been affirmed that to fulfill women's human rights, states must use all appropriate means to promote substantive equality. To this end, the Committee recognizes that states may need to adopt temporary special

Morningside Office Park
1st Floor, Wing A
Ngong Road
P.O Box 48136-00100
Nairobi, Kenya
Tel. +254 20 251 8361
www.reproductiverights.org

measures "in order to bring disadvantaged or marginalized persons or groups of persons to the same substantive level as others,"[11] which may include "tak[ing] measures in favour of women in order to attenuate or suppress conditions that perpetuate discrimination."[12]

One major element of women's right to equality and nondiscrimination is their ability to exercise reproductive autonomy—that is, to make decisions regarding whether and when to have a child without undue influence or coercion. For women to enjoy reproductive autonomy, their options must not be limited by lack of opportunities or results.[13] As such, it is crucial that women have access to reproductive health services, and that those services can be accessed with their consent alone.[14] In addition, reproductive health services must "be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[15]

II. The Right to Reproductive Health Care

The right of women and girls to access comprehensive reproductive health services receives broad protection under all the major international and regional human rights instruments, including the CESCR, which, under Article 12, recognizes "the right of everyone to the enjoyment of the highest standard of physical and mental health."[16] The Committee, in General Comment 14, has clarified that the right to health includes "the right to control one's health and body, including sexual and reproductive freedom,"[17] which "requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[18] In order to comply with this obligation, therefore, states are required to take "measures to improve child and maternal health, sexual and reproductive health services, including access to family planning … emergency obstetrics services and access to information, as well as to resources necessary to act on that information."[19] In the absence of these services, women and girls may experience unwanted and unsafe pregnancies and deliveries, possibly exposing them to life-threatening complications.

A. High Incidences of Preventable Maternal Mortality and Morbidity (Articles 2 (2), 3, 10 (2), 12)

This Committee, as well as other treaty-monitoring bodies (TMBs), have framed the issue of maternal mortality as a violation of women's right to health and right to life,[20] and have repeatedly expressed concern regarding the high maternal mortality and morbidity in Kenya. Particularly, during the review of Kenya in 2008, the Committee stated its "concern about the high maternal… mortality rates, the lack of adequately equipped maternal health facilities and skilled birth attendance … and de facto discrimination against poor women, older women and women with HIV/AIDS in access to maternal health care" and recommended that the government take concrete steps to address the problem.[21] Similarly, in 2011, the CEDAW Committee expressed concern regarding the high maternal mortality and recommended the government strengthen its efforts to reduce the rate and ensure that women, including those that live in rural areas have access to health care facilities.[22]

However, the WHO reports that Kenya's maternal mortality rate (MMR) has only decreased by 0.8% per year since 1990—well short of the target rate of 5.5%—which has left Kenya far off track in achieving its Millennium Development Goal target MMR of 175 deaths per 100,000 live births by 2015.[23] Currently, according to the same report, 400 Kenyan women and girls die per every 100,000 live births.[24] In some low-income urban areas, the estimated MMR is as high as 706 deaths per 100,000 births.[25] Citing the 2003 MMR of 414 deaths per 100,000 live births and the 2008-09 rate of 488 death per 100,000 live births, the government, in its current report to the Committee, stated that the "declining maternal health indicators are

worrying."[26] Although the current MMR has shown some improvement from the 2008-2009 rate, it has not reduced significantly from the rate in 2003.

In order to reduce Kenya's high maternal mortality rate, it is crucial that women have access to comprehensive care throughout the antenatal, delivery, and postnatal periods. However, access to quality maternity care remains a significant challenge, particularly for vulnerable groups of women, including low-income women, women with lower levels of education, and those in rural areas. According to the 2014 Kenya Demographic Health Survey summary report (2014 KDHS), although nine out of ten mothers reported at least one antenatal care visit,[27] only 58% of pregnant women attend the WHO recommended four or more antenatal care visits.[28] Moreover, a woman's geographic location has a significant impact on her access to antenatal care: for example, 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.[29] Women with higher education and those in a higher wealth quintile area are also more likely to attend the recommended antenatal care visits than their counterparts.[30]

Women also face challenges in obtaining quality delivery care; access to skilled providers during delivery is markedly worse for lower income, less educated, and rural women.[31] The 2014 KDHS 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.[32] Similarly, only 30% of women in the lowest wealth quintile delivered in a health facility compared to 93% of women in the highest wealth quintile.[33] Further, while the WHO recommends postnatal care starting an hour after giving birth for the first 24 hours in order to check for complications,[34] only 51% of women receive a postnatal checkup within two days of giving birth.[35] Disparities in access exist here as well: approximately 71% of women from the highest wealth quintile received postnatal care within two days as compared to only 29% of women from the lowest quintile.[36] In its current report, the government admits that there are some challenges in the health sector including "inadequate universal health coverage, inadequate budgetary allocation and improper resource use."[37]

(i) Abuse and Neglect of Women Seeking Maternal Health Services in Health Care Facilities

During the review of Kenya in 2008, the Committee, recommended the state take measures to ensure that all women have "access to skilled care free from abuse during pregnancy, delivery, postpartum, postnatal periods."[38] Nevertheless, according to a fact finding report conducted by the Center and FIDA- Kenya, women who attend maternal health care services are frequently neglected and encounter systematic abuse from health care professionals and staff.[39] These findings were further documented in a 2012 national public inquiry by the Kenyan National Human Rights Commission (KNHRC).[40] Women who attend these services often experience delays and a lack of adequate medical care. They also reported not being provided with adequate information about health services and available procedures, or were denied services.[41] They recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[42] For example, women arriving at Pumwani Maternity Hospital (PMH) recounted being told to find their own way to the delivery ward and to lift themselves onto the maternity bed while they were in labor.[43] The research also found delays in medical care during labor or waiting for stitches after delivery, including being stitched without anesthesia, causing women to endure excruciating pain.[44]

For instance, one woman, who gave birth at St. Mary's hospital in Langata, was subjected to verbal and physical abuse by a medical provider.[45] During the delivery, the medical provider treated her so roughly

that she feared for her and her baby's life. Since she was already in labor in an extremely vulnerable state, she was unable to stop the abusive treatment. The provider further subjected her to terrible pain and suffering by mutilating her genitals with a sharp object without her consent.[46] She was unable to obtain redress for the abuse and ill-treatment she suffered in the hands of the health care provider even though she reported the incident to the police, hospital authorities, as well as the Kenya Medical Practitioners and Dentist Board.

Another woman, who attended PMH, also recounted how hospital staff refused to assist her during labor and one nurse told her to "stop pretending to be in pain."[47] When her pain worsened, a staff member told her to continue suffering because she was responsible for her own pregnancy.[48] At night, when her pain intensified, she had to crawl to the nurses for assistance, who, instead of helping her, mocked her and asked if she was exercising.[49] When her water broke, she had to walk to the delivery ward on her own and was assisted by another patient who had just delivered her baby.[50]

In response to these egregious actions, the Center filed a case in the High Court of Kenya in 2012 highlighting the abuse that women face at health care facilities and seeking declaration that this treatment amounts to a violation of their human rights.[51] One of the petitioners in this case was mistreated and treated inhumanly at PMH. Even though she was in labor and severely bleeding upon arrival, she did not receive immediate care and was not taken to the operating room until two hours after her arrival.[52] Due to the delay in emergency care, her bladder ruptured after her caesarean section.[53] Her suffering was compounded by the fact that her wound was infected and the stitching had been poorly performed.[54] To make matters worse, during the days following her caesarean section, she was detained because she was unable to pay her hospital fees and was forced to sleep on a cold floor without any subsequent medical care.[55] On September 17, 2015, the Court passed a decision and found that the rights of the women, including their right to health, liberty and dignity, had been violated by the actions of the health care professionals at PMH and that they were discriminated against based on their socio-economic status. The court also ordered the government to pay monetary compensation to the petitioners for the damages they suffered as a result of these violations.

(ii) Illegal Detention of Women in Health Care Facilities for Failure to Pay Maternity Health Care Fees

In addition to the inhuman and abusive treatment women face when seeking maternal health care, the fact-finding report revealed that women in Kenya are often detained or denied access to services altogether when they fail to pay fees in private and public health care facilities.[56] 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."[57] The user fees for maternal health services reduces the likelihood that low-income, less-educated, or rural women will be able to access essential health care since fees make health care prohibitively expensive and inaccessible.[58]

For instance, women are often barred from entering the hospital if they are unable to afford the admission fee.[59] Once women are admitted to the hospital, they may be denied essential or life-saving treatment if they fail to pay the remaining balance of their hospital fees.[60] In many instances, women who are unable to pay the required fees for services rendered during their labor and delivery are detained at health care facilities, often without postnatal care or basic necessities such as bedding and food for themselves and their newborns.[61] Both petitioners in the Center's 2012 case, discussed above, were made to sleep on the floor during their detention—one was even forced to sleep next to a toilet, which routinely flooded.[62] The

internal and external mechanisms through which women can get redress for these violations of their human rights are ineffective.[63] Even when redress mechanisms are available, women often do not know about them or lack the necessary information about how to access them.[64] Accordingly, it is vital for the government to immediately comply with the recent judgment from the High Court, confirming that the detentions are human rights violations, by ensuring the detentions do not continue.

Inadequate Implementation of Presidential Directive on Free Maternity Care

As noted in Kenya's current report,[65] 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."[66] However, the government's report fails to detail the steps that are being taken to ensure the effective implementation of this declaration despite various reports indicating that serious problems with implementation have prevented women from accessing quality maternity services in practice. According to the KNCHR, hospital infrastructure and staffing cannot support the additional number of women who come seeking free maternal health care due to this declaration,[67] and the government has failed to allocate sufficient additional resources to remedy this issue.[68] Furthermore, there have been no clear guidelines set by the government about how to implement the free maternal services. Although some facilities have reportedly been 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.[69] In addition, although the government has said that maternal health services would be free for women, in reality, not all costs associated with giving birth have been eliminated.[70] Women still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.[71] Other key components of maternal health services, including antenatal and postnatal care, are also not covered under the directive.[72] Further, the Reproductive Healthcare Bill that was tabled in parliament provides for free antenatal care,[73] but does not cover postnatal care or provide any guidance regarding implementation of the Directive.

The declaration of free services has also not addressed the issue of abuse and mistreatment of women that attend maternal health services; in fact, the situation may have worsened as health care staff attempt to cope with an influx of delivery patients.[74] For instance, it was recently reported that a woman was forced to give birth while standing at Nyeri Hospital because there was no nurse to attend to her, and the baby fell on the floor and died from the impact.[75] The continued abuse following the Presidential Directive has been challenged in a recent case filed by the Center at the Bungoma High Court where the petitioner was neglected and abused by the hospital's staff. 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.[76]

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

During the 20008 review of Kenya, the Committee expressed concern "about the high number of unsafe clandestine abortions" and recommended the state "decriminaliz[e] abortion in certain situations, including rape and incest."[77] CEDAW Committee, in its 2011 concluding observations, also 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."[78] Similarly, 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.[79] Further, Kenya is a signatory of the Maputo Protocol of which Article 14(2) (c) obligates states parties to "protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[80] However, in its report, the government does not mention any efforts to bring its law in line with its human rights obligations or to address the prevalence of unsafe abortions.[81]

In Kenya, unsafe abortion accounts for one-third of maternal deaths,[82] which can be due to the numerous barriers women face in accessing safe abortion services. The laws governing abortion in Kenya are not only confusing, but also contradictory. While Kenya's 2010 Constitution provides for abortion in situations where a woman's life or health is at risk,[83] the Penal Code has not been revised to reflect this change.[84] Therefore, a woman could still face prosecution for seeking an abortion in circumstances allowed under the Constitution, such as when the pregnancy places her health at risk. Moreover, 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" since it is allowed under the 2006 Sexual Offences Act.[85] Even though this statement was removed during the revision of the guideline in 2014, the new guideline still provides 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."[86] Yet, neither the Constitution nor the Penal Code have expressly provided for this exception, and the government has not clarified whether this exception for rape applies under the 2010 Constitution. Further, although the proposed Reproductive Health Bill would codify the life and health exception from the Constitution, the Bill places unnecessary and likely unconstitutional restrictions on access under these circumstances. The Bill would require an adolescent to get the consent of parents or a guardian to get an abortion where her life or health is at risk,[87] which would violate her rights to life, health, and non-discrimination by putting her at heightened risk of dying due to the denials or delays in access to safe abortion care.

In fact, the Ministry of Health worsened the confusion surrounding the legality of abortion 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.[88] 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.[89] 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.[90] 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 compel women and girls to resort to clandestine abortions, which are often unsafe and subject women to grave pain and suffering. In its 2012 public inquiry, the KNCHR found that women resort to "crude methods," administered by unqualified persons to terminate pregnancies, due to the inaccessibility of abortion services in Kenya.[91] The KNHRC further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya.[92] A 2013 study conducted by the Ministry of Health estimated that nearly 465,000 abortions occur in Kenya each year.[93] Approximately 120,000 women sought care in health care facilities for unsafe abortion-related complications.[94] One study found that up to 60% of all

gynecologic emergency hospital admissions are a result of complications from unsafe abortion.[95] It concluded that the numbers of maternal death due to unsafe abortion is high.[96] At least 266 Kenyan women and girls die per 100,000 unsafe abortions each year.[97] The harshness of Kenya's abortion laws most heavily impacts young women[98] and low income women—for whom the unintended pregnancy rate is highest[99]—even where relatively safe abortion procedures are available, because the cost of these services often exceeds these women's financial resources.[100] In August 2015, a major newspaper in Kenya reported multiple stories of women who experienced unsafe abortion services with grave consequences to their life and health.[101] One such story is that of Beatrice, a college student, who procured an unsafe abortion and suffered kidney failure and was paralyzed as a result.[102]

In June 2015, the Center 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 case was brought on behalf of four petitioners, including "Wanjiku," a 15-year-old girl who had an unsafe abortion after an older man coerced her into having sex with him. Feeling anguished and fearing rejection from her family, Wanjiku decided to end the pregnancy but found safe abortion services to be unavailable. She was forced to seek care from an unqualified individual who used a dangerous method and botched the procedure. Afterwards, she started to vomit, bleed heavily, and swell—signs that her kidney was failing. However, when she could not afford to pay the medical bills for post-abortion care, she was detained by the hospital and forced to sleep on the floor. Doctors diagnosed Wanjiku with a kidney disease that requires regular dialysis, and ultimately a kidney transplant. Two organizations—East Africa Center for Justice and Kenya Christian Professionals Forum—have been granted permission to join the case as interested parties. The government has also filed its response to the claims in the case and the Center is in the process of preparing a response.

Post-Abortion Care

Access to post-abortion care (PAC) is essential to protect 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.[103] Moreover, a 2015 study found that 77% of Kenyan women seeking PAC suffered from moderate or severe complications.[104] However, barriers to access to PAC create delays in receiving essential treatment, which cause disproportionately higher rates of severe post-abortion complications.[105]

Reports by the KNCHR and the Center have revealed that women often delay seeking PAC due to fear of the social stigma and legal risks associated with the procedure, including harassment by the police and possible prosecution.[106] Although the government has stated that PAC "is legal and not punishable by any part of Kenya laws,"[107] this declaration only offers protection to the health care providers and not to women who seek PAC.[108] 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."[109] These delays can have fatal consequences for women that present with treatable conditions.[110]

Furthermore, medical providers may exacerbate the barriers women face in accessing PAC. Studies indicate that medical personnel—particularly nurses—are inadequately trained, so women suffering from complications may have to wait an extended period of time for a trained provider to attend to their medical needs.[111] Medical providers may also make women feel like criminals instead of patients by insulting and shaming them for having undergone abortion.[112] Some medical providers may even be unaware that

providing PAC is legal,[113] particularly after the Ministry of Health withdrew the Standards and Guidelines which also provided guidance on the provision of PAC. Furthermore, the recording of PAC in a woman's medical history can expose her to harassment by law enforcement officials or family members,[114]—a predicament medical staff use to extort bribes from patients.[115]

C. Lack of Access to Family Planning Information and Services

In its 2011 concluding observations, the CEDAW 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."[116] This is similar to the concern expressed by this Committee in 2008, about "the limited access to sexual and reproductive health services and contraceptives, especially in rural and deprived urban areas,"[117] and the recommendation for the government to "ensure affordable access for everyone, including adolescents, to comprehensive family planning services [and] contraceptives."[118] However, Kenya's report, despite acknowledging the recommendation of the Committee on family planning, does not discuss the effort the government is making to ensure access to family planning information and services.[119]

A woman's ability to choose her preferred method of contraception is instrumental in enabling her to control her own fertility and to decide whether and when to bear a child.[120] However, according to the 2014 KDHS, only about half of Kenyan women (53.4%) are able to access modern methods of contraceptives,[121] an increase of only seven percentage points from the 2008 rate.[122] 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.[123] The 2014 KDHS found that although women from all demographic backgrounds have significant unmet family planning needs,[124] the rate of unmet need falls precipitously as wealth increases with a rate of 29% unmet need in the lowest wealth quintile and only 11% in the highest quintile.[125] In addition, usage disparities are even more pronounced by geographic area[126] 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—[127]use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.[128]

These disparities in usage rates are due to a variety of barriers to women's and adolescent's 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.[129] 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.[130] Moreover, a woman's preferred method of contraception is often unavailable[131] or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members.[132] 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.[133]

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.[134] For example, in the Center's fact-finding report, one young woman recounted being turned away when she

attempted to get an intrauterine device. "[T]hey said no at the government facility. They said you are a Muslim girl, you are going to burn in hell. She was a Muslim nurse and refused to give me contraceptives."[135] Young people in Kenya also lack formal and comprehensive sex education,[136] resulting in misinformation about their reproductive health, including concerns about poor outcomes from using contraceptives.[137] These misconceptions lead to lower contraceptive use rates and a higher incidence of unplanned and unwanted pregnancies.[138]

Access to Emergency Contraception

Many women and girls could prevent unplanned or unwanted pregnancies by using emergency contraception (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.[139] Indeed, the National Guideline on the Management of Sexual Violence in Kenya also requires that EC be available 24 hours a day for survivors of sexual violence in all health facilities.[140] In Kenya, nine products of EC are registered,[141] and the MOH broadly recommends its use for those "who have had unprotected sexual intercourse and desire to prevent pregnancy."[142] The Ministry of Health also has recognized that EC "is an important component of adolescent reproductive health."[143] 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.[144]

However, in practice, there are significant barriers to accessing EC. Consistent stock outs in pharmacies and shipment delays prevent women and girls from reliably accessing the medicine.[145] Some pharmacists also decline to distribute EC altogether or refuse to dispense it without a prescription,[146] although EC is registered in Kenya as an over-the-counter medicine.[147] Despite the MOH 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.[148] Moreover, adolescents are routinely denied access to EC for arbitrary or discriminatory reasons such as "the person look[ed] young."[149] A 2014 study found out that only 18% of women and girls surveyed in Nairobi have ever used EC.[150] 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.[151] Women's access to 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—in order to ensure their right to reproductive autonomy.[152]

III. DISCRIMINATION RESULTING IN GENDER-BASED VIOLENCE AND HARMFUL TRADITIONAL PRACTICES AGAINST WOMEN AND GIRLS

Harmful practices, including physical and sexual violence, are manifestations of the inequality and discrimination that women and girls encounter in their day-to-day lives. Gender-based violence has been addressed in many of the concluding observations on Kenya issued by various treaty monitoring bodies.[153] The Human Rights Committee stated in its 2012 concluding observations that Kenya "should adopt a comprehensive approach to preventing and addressing FGM, and gender-based violence in all its forms and manifestations."[154] In 2008, this Committee also recommended that "the State party raise public awareness of the need to abolish laws and customs which discriminate against women and adopt … Gender Equality and Affirmative Action Bills."[155]

The Kenyan government noted in its report that it has passed and introduced various legislation to address issues of gender-based violence, including the repealing of Section 38 of the Sexual Offences Act (No. 3 of 2006) which carried sanctions for false sexual violence allegations.[156] However, the government also acknowledges that "a number of gender facilitative bills including the marriage bills, have for years remained unlegislated."[157] 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.

A. *Sexual and Domestic Violence against Women and Girls*

In its 2008 concluding observations, the Committee noted the high rate of domestic violence and "the low number of complaints filed by victims.[158] Despite this chronic underreporting, data from various sources demonstrate that violence against women, sexual and otherwise, is prevalent in Kenya. In March 2013, the Gender Minister reported that 32% of females in Kenya have experienced sexual violence.[159] The 2014 KDHS shows that approximately 44% of ever-married women have experienced sexual or physical violence by their husband or partner, [160] which is not a significant decrease from 2008-2009 KDHS where 47% of ever-married women reported to having experienced such violence.[161] In addition, roughly 28% women aged 20-29 have experienced some form of violence in the previous 12 months preceding the survey.[162] Furthermore, women who were divorced, separated, or widowed are more likely than their married counterparts to report past experiences of sexual or physical violence.[163]

Although the domestic legal framework in Kenya provides a mechanism for addressing violence against women and girls,[164] this framework has a number of gaps. The passage of the *Sexual Offences Act of 2006* represented an improvement over earlier laws on sexual violence, but still the government has not implemented the Committee's recommendation of explicitly criminalizing marital rape and domestic violence.[165] This is significant given that more than one in three female survivors of sexual violence report that the perpetrator was either a current or former husband or boyfriend.[166]

In addition, survivors of sexual and physical violence lack access to needed services and face a number of barriers that prevent them from receiving meaningful assistance from medical or legal professionals. These barriers include a lack of comprehensive facilities where victims can report complaints and receive medical treatment, including emergency contraceptives; a lack of awareness among sexual violence victims of the services that are available; difficulties in proving sexual violence; and the high cost of obtaining services after sexual violence.[167] Further, health care providers may lack adequate training or an understanding of the appropriate medical and gender-sensitive response toward sexual violence.[168] In addition, many women and girls are reluctant to engage in the justice system because the police often harbor negative attitudes toward victims. Although designated 'Gender Desks' were established in some police stations to assist victims of gender based violence, poor equipment and infrastructure, weak investigations, and inadequate training have combined to undermine their effectiveness.[169] Therefore, women and girls who experience violence are subjected to social stigma, humiliation, and bribe requests in police stations.[170] Legal assistance is not readily available, which makes access to remedies daunting and disincentivizes the use of the legal system for redress.[171]

Sexual Violence against Girls and Adolescents, Particularly in Educational Settings

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.[172] A household survey of more than 3,000 young people aged 13 to 24 revealed that three out of four had experienced physical, sexual, or emotional violence.[173] Of those who had experienced violence, six out of ten have been physically abused.[174] Rape is rarely reported as a result of pervasive social stigma and a deep mistrust in police and the criminal justice system.[175] A 2012 UNICEF study determined that only 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.[176] Sexual violence against girls and adolescents is also a significant problem in schools and other educational settings. According to a 2012 UNICEF study of 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.[177] 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.[178]

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.[179] The High Court of Kenya at Nairobi not only found the teacher civilly liable for sexual assault, but also determined that the government and Teachers Service Commission (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.[180] Although the TSC circular, or employee guidelines, mentions disciplinary action for the sexual assault of students,[181] the circular fails to indicate clear mechanisms for disciplinary action or provide sexual assault survivors with psychological or essential health care.[182] The Government of Kenya must ensure that the TSC complies with order of the High Court to end the practice of "shuffl[ing abusive teachers] from one school to another, and finally, content itself with dismissals."[183] The Government must also follow the Court's order to "put in place an effective mechanism"[184] to ensure that teachers are held accountable for any sexual abuse that they commit against their students.

B. *Female Genital Mutilation (FGM)*

Female genital mutilation (FGM)—"the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons"—[185] disrupts the natural functioning of girls' and women's bodies and leaves them susceptible to serious health risks including pain, shock, bacterial infection, hemorrhaging, or death.[186] FGM has been internationally recognized as a human rights violation as "an extreme form of discrimination against women," and violates the "rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death."[187] In 2008, the Committee called on to the government to pass a legislation to criminalize FGM, ensure implementation of the law and raise the awareness of the community regarding the harmful effect of FGM.[188] In its 2013 concluding observations, the CAT Committee stated that Kenya "should redouble its efforts to eradicate the practice of female genital mutilation, including through awareness-raising campaigns and by prosecuting and punishing perpetrators of such acts. The State party should ensure that all measures to combat the practice comply with legal safeguards."[189]

Even though Kenya has implemented some parts of these recommendations by passing the Prohibition of Female Genital Mutilation Act, 2011 and establishing an Anti-FGM Board,[190] it has failed to take concrete steps to effectively enforce the law, which is demonstrated in the very high rate of the practice: FGM is

universal in Northeastern Kenya, where 97.5% of women have undergone FGM, compared with only 8% of women in Nairobi.[191] Without a robust enforcement mechanism and equitable implementation across the country, the Prohibition of Female Genital Mutilation Act will remain ineffective.

We hope that the Committee will consider addressing the following questions to the Government of Kenya:

Maternal Health

1. What concrete steps is the Government of Kenya taking to reduce the high maternal mortality rate? How does the government plan to expand access to quality health care throughout the duration of a woman's pregnancy, including antenatal, delivery, and postnatal care, including for low-income women and those in rural areas?

2. What steps is the Government taking to effectively implement the Presidential Directive in order to ensure all women have access to free maternal health care? What measures are being taken to ensure that there are sufficient resources to properly implement the free maternal health care program? How is the Government going to ensure that hospitals are equipped to deal with the increased number of women seeking maternal health care services?

3. What measures are being taken to eliminate the practice of detaining women in both public and private hospitals who cannot afford hospital fees after giving birth? How is the government working to improve the training of healthcare providers about patients' rights and eliminate the abuse and neglect of women by medical and hospital staff? What steps are being taken to protect women and girls from gender-based violence and abuse in healthcare facilities? How does the government propose to ensure that women are able to report and seek redress for such abuses?

Unsafe Abortion and Lack of Access to Post-Abortion Care

4. What measures will the government undertake to review and clarify the existing abortion laws to ensure that women have access to safe, legal abortion services and post-abortion care, as provided under the 2010 Constitution? When does the Government intend to issue new guidelines clarifying the circumstances in which health care professionals can provide safe, legal abortion services under the 2010 Constitution? What steps is the Government taking to ensure that its abortion laws are consistent with the international and regional human rights standards by allowing abortion in cases of rape, incest, and fetal anomalies?

5. How will the government reduce the high levels of unsafe abortions in Kenya? What steps has the government taken to ensure equal opportunities for rural and low-income women and adolescents to receive respectful and comprehensive post-abortion care?

Access to Family Planning Information and Services

6. What is being done to ensure that women and adolescents have access to the full range of family planning and contraceptive methods and information? How does the government propose to improve awareness about, and the availability of, emergency contraception?

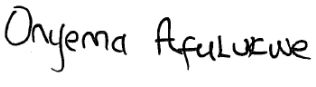
Physical and Sexual Violence against Women and Girls and FGM

7. What measures will Kenya take to ensure that victims of sexual violence have access to necessary support services, including medical and legal resources? How will the government ensure that health care professionals and police handle cases of sexual violence in a manner that is sensitive to the needs of victims? What progress has the government made towards criminalizing marital rape and domestic violence?

8. How will the government ensure the implementation of the High Court decision holding teachers accountable for sexual violence in schools? What steps is it taking to guarantee the TSC complies with the order to rewrite the circular to ensure that disciplinary proceedings are effective and uniform, and that survivors of sexual assault in schools receive the medical and psychological support they require.

9. What concrete steps is the government of Kenya taking to effectively implement the Female Genital Mutilation Act, 2011, particularly in rural areas, to eradicate the practice of FGM from Kenya?

Sincerely,



Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights

Onyema Afulukwe
Senior Legal Advisor
Africa Program
Center for Reproductive Rights

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[1] International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].
[2] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, 34 U.N. GOAR, Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981 [hereinafter CEDAW]; International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into* force Mar. 23, 1976) [hereinafter ICCPR]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter African Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) [hereinafter Maputo Protocol].
[3] Human Rights Committee, *Concluding Observation: Jordan*, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).
[4] Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) (emphasis added).
[5] Human Rights Committee, *Concluding Observation: Dominican Republic*, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).
[6] Human Rights Committee, *Concluding Observation: Guatemala*, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).
[7] Human Rights Committee, *Concluding Observation: Cape Verde*, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).
[8] Human Rights Committee, *Concluding Observation: Canada*, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).
[9] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, (34th Sess., 2005), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 7-8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *General Comment No. 16*].
[10] *Id.* paras. 6-7.
[11] *Id*. para. 15.
[12] *Id.*
[13] Rebecca Cook, *Human Rights and Reproductive Self Determination*, 44 THE AMERICAN UNIVERSITY LAW REVIEW 975, 1007 (1995).
[14] *Id*.
[15] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, art. 24, para. 31(e), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW *General Recommendation No. 24*].
[16] ICESCR, *supra* note 1, art. 12.

[17] ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, para 8 (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 14, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*)
[18] *Id*. para 21.
[19] *Id*. para. 14.
[20] ESCR Committee, *Gen. Comment No. 14*, *supra* note 17, para. 21; *see, e.g.*, *CEDAW Committee Concluding Observations*: *Belize*, para. 56 (1999), U.N. Doc. A/54/38; *Colombia*, para. 393 (1999), U.N, Doc A/54/38; *Dominican Republic*, para. 337 (1998) U.N. Doc A/53/38.
[21] CESCR Committee, *Concluding Observations: Kenya*, para. 32, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[22] CEDAW Committee, *Concluding Observations: Kenya*, para. 37 & 38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[23] *See* WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2013 27, 29 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter WHO, TRENDS IN MATERNAL MORTALITY]; *see also* UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 28–29 (2013), *available at* *h*ttp://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2013/English2013.pdf.
[24] *See id.*, at 33. The 2008–2009 Kenya Demographic Health Survey (KDHS) reported an even higher maternal mortality ratio (MMR) at 488 deaths per 100,000 live births. KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2008–09 273 (2010), *available at* http://dhsprogram.com/pubs/pdf/FR229/FR229.pdf [hereinafter KDHS 2008–09].
[25] GUTTMACHER INSTITUTE, FACT SHEET: ABORTION AND UNINTENDED PREGNANCY IN KENYA (May 2012), *available at* www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf [hereinafter GUTTMACHER FACT SHEET 2012].
[26] Kenya, *Consideration of reports submitted by States parties under articles 16 and 17 of the International Covenant of Economic Social and Cultural Rig*hts*: combined second to fifth periodic reports of State Parties*, para 180, U.N. Doc. E/C.12/KEN/2-5 (2013) [Kenya State Party Report 2013].
[27] *See* KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY: KEY INDICATORS 23 (2015) [hereinafter KDHS 2014 SUMMARY], *available at* http://dhsprogram.com/pubs/pdf/PR55/PR55.pdf.
[28] *See id.* at 23, 24 tbl.3.13 (2015); *see also* WORLD HEALTH ORGANIZATION, *Antenatal Care (at least 4 visits)* (2015), http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited July 6, 2015).
[29] KDHS 2014 SUMMARY, *supra* note 27, at 23.
[30] *Id.*
[31] *See id.*, at 24, tbl.3.13 & 25, tbl.3.14.
[32] *Id.*
[33] *Id.*
[34] *See* WHO, WHO RECOMMENDATIONS ON POSTNATAL CARE OF THE MOTHER AND NEWBORN 25 (2013), *available at* http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf.
[35] *See* KDHS 2014 SUMMARY, *supra* note 27, at 27.
[36] *See id.*
[37] Kenya State Party Report 2013, *supra* note 26, at para. 187.
[38] CESCR Committee, *Concluding Observations: Kenya*, para. 32, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[39] The examples cited herein come from the Center for Reproductive Rights and FIDA-Kenya's fact-finding report, CENTER FOR REPRODUCTIVE RIGHTS & FIDA KENYA, FAILURE TO DELIVER: VIOLATIONS ON WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 26 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [hereinafter FAILURE TO DELIVER].
[40] KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, REALIZING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR REALITY? A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA (2012), *available at* http://www.knchr.org/portals/0/reports/reproductive_health_report.pdf [hereinafter KNCHR Report 2012].
[41] FAILURE TO DELIVER, *supra* note 39, at 7-10.
[42] *See id.*, at 28–32; *see also* Abdi Latif Dahir, *Kenya's Health Workers Claim Mismanagement*, AL JAZEERA (Jan. 13, 2014), http://www.aljazeera.com/indepth/features/2014/01/kenya-health-workers-claim-mismanagement-20141751735209910.html (last visited July 6, 2015).
[43] FAILURE TO DELIVER, *supra* note 39, at 28; KNCHR REPORT 2012, *supra* note 40, at 31.
[44] *Id.* at 29, 33-35
[45] *Id.*, at 30, 32, 37.

[46] *Id.*
[47] *Id.* at 28 (citing focus group discussion with an unnamed participant, Nairobi, Feb. 9, 2007).
[48] *Id.*
[49] *Id.*
[50] *Id.* at 18.
[51] Awuor & Another v. A.G. of Kenya & 4 Others, Petition No. 562 of 2012, 7–9 (High Ct. Kenya, Nairobi).
[52] *Id.* at 21.
[53] *Id.* at 24.
[54] *Id.*
[55] *Id.* at 26.
[56] FAILURE TO DELIVER, *supra* note 39, at 51–52, 56–58; KNCHR REPORT 2012, *supra* note 40, at 112; *see also* Gabe Joslow, *Women Detained at Kenyan Maternity Hospital Demand Justice*, VOICE OF AMERICA (Dec. 10, 2012), http://www.voanews.com/content/women-detained-at-maternity-hospital-in-kenya-demand-justice/1562030.html (last visited July 6, 2015).
[57] FAILURE TO DELIVER, *supra* note 39, at 51–52, 56–58; *see also* CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[58] FAILURE TO DELIVER, *supra* note 39, at 52.
[59] One woman recounted witnessing another woman near labor being harassed at a hospital entrance and then turned away because she could not pay the admission fee. *See id.*, at 52–53.
[60] *Id.* at 53–54; KNCHR REPORT 2012, *supra* note 40, at 54.
[61] *Id.* at 56.
[62] Awuor & Another v. A.G. of Kenya & 4 Others, Petition No. 562 of 2012, 45 (High Ct. Kenya, Nairobi).
[63] FAILURE TO DELIVER, *supra* note 39, at 63.
[64] *Id.* at 72–73.
[65] *See* Kenya State Party Report 2013, *supra* note 26, at para. 182.
[66] *Maternal Care Free, President Kenyatta Announces*, DAILY NATION (June 1, 2013), http://www.nation.co.ke/News/Govt-rolls-out-free-maternal-care/-/1056/1869284/-/gywvvrz/-/index.html (last visited July 6, 2015).
[67] *See* KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, IMPLEMENTING FREE MATERNAL HEALTH CARE IN KENYA: CHALLENGES, STRATEGIES, AND RECOMMENDATIONS 6-7 (2013) [hereinafter KNCHR, FREE MATERNAL HEALTH CARE 2013], *available at* http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf.
[68] Currently, only about 6% of Kenya's budget is allocated to health, falling short from its commitment under the Abuja declaration to allocate 15% of its budget to health: Press Release, Federation of Women Lawyers Kenya, *On the Increasingly Troubling Trend of Maternal Deaths in Kenya* 1 (Jan. 20, 2014) *available at* http://fidakenya.org/wp-content/uploads/2014/02/PRESS-STATEMENT-ON-THE-INCREASING-TROUBLING-TREND-OF-MATERNAL-DEATHS-IN-KENYA-FINAL-1.pdf; *see* AFRICAN SUMMIT ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, 5, O.A.U. Doc. OAU/SPS/ABUJA/3 (Apr. 27, 2001), *available at* http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.
[69] A matron at PMH explained that the government was reimbursing them at a flat rate of Ksh 5,000 per delivery, even though the hospital used to charge Ksh 5,000 for normal deliveries and Ksh 10,000 for caesarian sections. This created a critical financial gap at the hospital: KNCHR, FREE MATERNAL HEALTH CARE 2013, *supra* note 67, at 6.
[70] Henry Owino, *Not So Free After All: Delivery Services the Only Free Package on Maternal Health Care*, REJECT 1, 4 (2013) [hereinafter Owino: *Not so Free*], *available at* http://issuu.com/awcfs/docs/reject_online_issue_87.
[71] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 6 (High Ct. Kenya, Bungoma).
[72] Owino: *Not so Free*, *supra* note 70, at 1, 4.
[73] *See* Reproductive Health Care Bill (2014), Senate Bills No. 17, KENYA GAZETTE SUPPLEMENT NO. 57 §§ 19-21, *available at* http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2014/ReproductiveHealthCareBill2014__1_.pdf [hereinafter Reproductive Health Care Bill (2014)].
[74] *See, e.g.*, Alinoor Moulid Bosh, *Dying to Give Birth in Northern Kenya*, AL JAZEERA (Jan. 15, 2015), http://www.aljazeera.com/indepth/features/2015/01/dying-give-birth-northern-kenya-201511411540230402.html Bosh(last visited July 6, 2015) [hereinafter Bosh, *Dying to Give Birth*]; Abdi Latif Dahir, *Kenya's Health Workers Claim Mismanagement*, AL JAZEERA (Jan. 13, 2014), http://www.aljazeera.com/indepth/features/2014/01/kenya-health-workers-claim-mismanagement-20141751735209910.html (last visited July 6, 2015).

[75] *Pregnant Woman Forced to Give Birth While Standing in Nyeri Hospital*, STANDARD MEDIA, http://www.standardmedia.co.ke/ktn/video/watch/2000074070/-pregnant-woman-forced-to-give-birth-while-standing-in-nyeri-hospital (last visited June 18, 2015); *see also* Bosh, *Dying to Give Birth*, *supra* note 74.
[76] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 4 (High Ct. Kenya, Bungoma).
[77] CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[78] CEDAW Committee, *Concluding Observations, Kenya*, para. 38, U.N. Doc. CEDAW/C/Ken/CO/7 (2011).
[79] CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[80] Maputo Protocol, *supra* note 2, art. 14(2)(c).
[81] *See* Kenya Periodic Report 2013, *supra* note 26.
[82] KENYA MINISTRY OF HEALTH, NATIONAL POST ABORTION CARE CURRICULUM FOR SERVICE PROVIDERS xii (undated) (A foreword by the Director of Medical Service, Ministry of Health). Unsafe abortion contributes to the high maternal mortality rate in Kenya. *See* GUTTMACHER FACT SHEET 2012, *supra* note 25.
[83] CONST. REPUBLIC OF KENYA, 2010, art. 26(1)(4).
[84] The Penal Code, (2009) Cap. 63 §§ 158-160 (Kenya).
[85] MINISTRY OF PUBLIC HEALTH & SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 21 (2d ed., 2009), *available at* http://www.svri.org/nationalguidelines.pdf [hereinafter NATIONAL GUIDELINES ON SEXUAL VIOLENCE].
[86] MINISTRY OF HEALTH, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA Annex 11, 78 (3d ed., 2014) [hereinafter NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE, 2014].
[87] *See* Reproductive Health Care Bill (2014), *Supra note* 73, at §§ 20.
[88] *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 (last visited July 6, 2015) [Muchangi, *Alarm Over Unsafe Abortion*]; Joyce Chimbi, *Kenya: A Society at Crossroads Over Devastating Impact of Unsafe Abortions*, THE STAR (Feb. 16, 2015), *available at* http://allafrica.com/stories/201502160844.html (last visited July 6, 2015) [hereinafter Chimbi, *Crossroads Over Unsafe Abortion*].
[89] Ministry of Public Health and Sanitation, Memo to health care providers on abortion training and Medabon (2014) (on file with the Center).
[90] *See, e.g.*, Chimbi, *Crossroads Over Unsafe Abortion*, *supra* note 88.
[91] KNCHR REPORT 2012, *supra* note 40, at 47.
[92] *Id.* at 66–67.
[93] MINISTRY OF HEALTH., INCIDENCE AND COMPLICATIONS OF UNSAFE ABORTION IN KENYA: KEY FINDINGS OF A NATIONAL STUDY 7 (2013), *available at* https://www.guttmacher.org/pubs/FB-abortion-in-Kenya-2013.pdf [hereinafter MINISTRY OF HEALTH, INCIDENCE OF UNSAFE ABORTION 2013].
[94] *See id.*
[95] *Id.; see also* Bernard Muthaka, *Penal Code Slowing Down Constitutional Abortion Care Services*, STANDARD DIGITAL (Dec. 9, 2012), http://www.standardmedia.co.ke/?articleID=2000072431&story_title=Kenya-Penal-code-slowing-down-constitutional-abortion-care-services (last visited July 6, 2015)
[96] GUTTMACHER FACT SHEET 2012, *supra* note 25.
[97] MINISTRY OF HEALTH, INCIDENCE OF UNSAFE ABORTION 2013, *supra* note 93, at 8.
[98] FAILURE TO DELIVER, *supra* note 39, at 24–25 (finding that half of the women treated by a hospital for complications from unsafe abortion were under the age of 20).
[99] GUTTMACHER INSTITUTE, IN BRIEF: ABORTION AND UNINTENDED PREGNANCY IN KENYA 3 (2012) [hereinafter GUTTMACHER IN BRIEF 2012], *available at* http://www.guttmacher.org/pubs/IB_UnsafeAbortionKenya.pdf.
[100] *Id.* at 2. ("Women and men interviewed in 2002–2003 were aware that the strict abortion law led women to procure unsafe procedures from 'quacks,' and they believed that rich women could obtain relatively safe abortions, while poorer women were more likely to die from unsafe procedures."); CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 59-60 (2010) [hereinafter IN HARM'S WAY], *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf.
[101] *See* Hudson Gumbihi, *Nairobi doctor reveals why more women are terminating pregnancies*, STANDARD DIGITAL (August 17, 2015), *available at* http://www.standardmedia.co.ke/health/article/2000173096/nairobi-doctor-reveals-why-more-women-are-terminating-pregnancies; Peace Loise & Brigid Chemweno, *Crude methods Kenyan girls are using to abort*, STANDARD DIGITAL, (August 16, 2015), *available at* http://www.standardmedia.co.ke/health/article/2000173104/crude-methods-kenyan-girls-are-using-to-abort ((last visited August 30, 2015).; Mwangi; Muraguri & Linah Benyawa, *Girls in the Coast region using 'dangerous' drugs to end pregnancies*, STANDARD DIGITAL, (August 18, 2015), *available at*

http://standardmedia.co.ke/article/2000173119/girls-using-dangerous-drugs-to-end-pregnancies (last visited August 30, 2015).
[102] Vincent Mabatuk, *Rouge medical practitioners operate with amazing ease in Nakuru*, STANDARD DIGITAL, (August 17, 2015), *available at* http://standardmedia.co.ke/article/2000173121/rogue-medical-practitioners-operate-with-amazing-ease-in-nakuru?articleID=2000173121&story_title=rogue-medical-practitioners-operate-with-amazing-ease-in-nakuru&pageNo=1 (last visited August 30, 2015).
[103] Muchangi, *Alarm Over Unsafe Abortion*, *supra* note 88.
[104] Severe complications are defined as death, sepsis, running a temperature above 37.9 degrees Celsius, evidence of mechanical injury or foreign body, shock, pulse less than 119 beats per minute, organ or system failure, generalized peritonitis, or tetanus. Moderate complications include offensive products of conception, running a temperature between 37.3 and 37.9 degrees Celsius, or localized peritonisis. *See*. 65.4 percent of post-abortion care relied on vacuum aspiration, 7.9 percent utilized dilation and curettage, 7.6 involved misoprostol, and 19.1 relied on other methods including the use of forceps, a finger, or hand. *See* Abdhalah Kasiira Ziraba et al., *Unsafe Abortion in Kenya: A Cross-Sectional Study of Abortion Complication Severity and Associated Factors*, 15(34) BMC PREGNANCY & CHILDBIRTH 3–6 (2015), *available at* http://www.biomedcentral.com/content/pdf/s12884-015-0459-6.pdf [Ziraba, *Study of Abortion Complication Severity*].
[105] *See id.* at 3.
[106] *See* KNCHR REPORT 2012, *supra* note 40, at 49–59; IN HARM'S WAY, *supra* note 100, at 76.
[107] NATIONAL POST ABORTION CARE CURRICULUM FOR SERVICE PROVIDERS: TRAINEES HANDBOOK 1-24, *available at* http://www.postabortioncare.org/sites/pac/files/MOHKen_National_Curriculum_Service_Providers.pdf.
[108] The training manual provides that "[c]omprehensive PAC is a life-saving procedure that should be available to all women and provision of comprehensive post-abortion care does not lead to punishment or withdrawal of registration of the service provider." It does not, however, address the issue of women who are deterred from seeking PAC for fear of prosecution. *Id.* at 1-24.
[109] *See* Ziraba, *Study of Abortion Complication* Severity, *supra* note 104, at 7.
[110] *See id.*
[111] GUTTMACHER IN BRIEF 2012, *supra* note 99, at 2. IN HARM'S WAY, *supra* note 100, at 88–90.
[112] FAILURE TO DELIVER, *supra* note 39, at 25; IN HARM'S WAY, *supra* note 100, at 92–93.
[113] IN HARM'S WAY, *supra* note 100, at 76–78 (noting further that fears of prosecution are not unfounded despite the legality of the treatment).
[114] FAILURE TO DELIVER, *supra* note 39, at 25.
[115] IN HARM'S WAY, *supra* note 100, at 90–92.
[116] CEDAW Committee, *Concluding Observations: Kenya*, para. 38(d), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[117] CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[118] *Id*.
[119] *See* Kenya Periodic Report 2013, *supra* note 26, at 41.
[120] Maputo Protocol, *supra* note 2, arts. 14(1) (a)-(c).
[121] *See* KDHS 2014 Summary, *supra* note 27, at 17, tbl.3.9. A small percentage of women also rely upon traditional methods of birth control which KDHS counts toward satisfied demand for family planning. *Id.*
[122] KDHS 2008–09, *supra* note 24, at 61 (reporting that 46% of women used modern contraceptives).
[123] *See* KDHS 2014 Summary, *supra* note 27, at 20.
[124] *See id.* at 20–21 & tbl.3.11.
[125] *See id.* at 20.
[126] *See id.* at 17–19.
[127] *See* CENTER FOR ECONOMIC AND SOCIAL RIGHTS, FACT SHEET 4: KENYA *available at* http://www.cesr.org/downloads/Kenya%20Fact%20Sheet.pdf.
[128] *See* KDHS 2014 Summary, *supra* note 27, at 18–19.
[129] *See* Rhoune Ochako et al., *Barriers to Modern Contraceptive Methods Uptake Among Young Women in Kenya: A Qualitative Study*, 15 BMC PUB. HEALTH 118, 119 (2015), *available at* http://www.biomedcentral.com/content/pdf/s12889-015-1483-1.pdf [Ochako, *Barriers to Modern Contraceptive Methods*]; *see also* Joyce Mulama, *Health-Kenya: Contraceptives: Stock-Outs Threaten Family Planning*, INTER PRESS SERVICE (May 15, 2009), *available at* http://www.ipsnews.net/2009/05/health-kenya-contraceptives-stock-outs-threaten-family-planning/ (last visited July 6, 2015).
[130] IN HARM'S WAY, *supra* note 100, at 45.
[131] *Id.*, at 44–45.

[132] Young, unmarried women who wish to use condoms, in particular, face stigma. Unmarried women feel that they may not ask for methods of contraception as freely as their married counterparts. *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 129, at 119; UNFPA, *Family Planning in Kenya: Not for Women Only* (Jul. 1, 2009), *available at* http://www.unfpa.org/public/News/pid/3015 (last visited July 6, 2015).
[133] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 129, at 119.
[134] IN HARM'S WAY, *supra* note 100, at 46.
[135] *Id.*, at 46.
[136] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 129, at 126.
[137] IN HARM'S WAY, *supra* note 100, at 47.
[138] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 129, at 126; IN HARM'S WAY, *supra* note 100, at 47–48.
[139] WHO, *Emergency Contraception*, *Fact Sheet No. 244* (2012), http://www.who.int/mediacentre/factsheets/fs244/en/ (last visited July 6, 2015).
[140] NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE, 2014, *supra* note 86, at 14.
[141] Eight registered EC products are available from a pharmacist without a prescription, while one registered EC product, Optinor, is only available from family planning clinics. International Consortium for Emergency Contraception, *EC Status and Availability: Kenya* (2015), http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/kenya/ (last visited, July 6, 2015) [hereinafter *EC Status and Availability*].
[142] MINISTRY OF PUBLIC HEALTH & SANITATION, DIVISION OF REPRODUCTIVE HEALTH (KENYA), EMERGENCY CONTRACEPTION: HEALTH CARE PROVIDERS QUICK REFERENCE GUIDE 2 (2008) *available at* www.popcouncil.org/uploads/pdfs/RH_ECQuickRefGuide.pdf.
[143] *Id.* at 1.
[144] INTERNATIONAL CONSORTIUM FOR EMERGENCY CONTRACEPTION, COUNTING WHAT COUNTS: TRACKING ACCESS TO EMERGENCY CONTRACEPTION 1 (2013), *available at* http://www.cecinfo.org/custom-content/uploads/2013/05/ICEC-Kenya-Fact-Sheet-2013.pdf.
[145] IN HARM'S WAY, *supra* note 100, at 47; *EC Status and Availability*, *supra* note 143.
[146] *Id.*, at 47.
[147] International Consortium for Emergency Contraception, *EC Status and Availability: Kenya* (2015), http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/kenya/ (last visited, July 6, 2015).
[148] IN HARM'S WAY, *supra* note 100, at 47–48.
[149] *Id.*, at 47.
[150] Dawn Chin-Quee et al., *Repeat Use of Emergency Contraceptive Pills in Urban Kenya and Nigeria* 40 INT'L PERSPECT. ON SEXUAL & REPRO. HEALTH 127, 127 (Sept. 2014) *available at* http://www.guttmacher.org/pubs/journals/4012714.pdf.
[151] IN HARM'S WAY, *supra* note 100, at 44.
[152] Maputo Protocol, *supra* note 2, art. 14(1)(b)-(c).
[153] *See, e.g.*, Human Rights Committee, *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/C/KEN/CO/3 (2012); CEDAW Committee, *Concluding Observations: Kenya*, paras. 17–24, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Human Rights Council, *Universal Periodic Review: Kenya*, para. 101.48-53, U.N. Doc. A/HRC/15/8 (2010).
[154] Human Rights Committee, *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/C/KEN/CO/3 (2012).
[155] CESCR Committee, *Concluding Observations: Kenya*, para. 14, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[156] Kenya Periodic Report 2013, *supra* note 26, at para. 98.
[157] *Id.*, at para. 57 (describing the bills that were passed or introduced to address issues of sexual violence in Kenya).
[158] CESCR Committee, *Concluding Observations: Kenya*, para. 22, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[159] Lillian Onyango, *Fight against Sexual Violence in Kenya 'Dimmed'*, DAILY NATION (Mar. 22, 2013), http://www.nation.co.ke/News/-/1056/1727326/-/wq41n6z/-/index.html (last visited July 6, 2015).
[160] *See* KDHS 2014 SUMMARY, *supra* note 27, at 59, tbl. 3.40 (relying upon the statistics from the 41–49 year old women, 44% of whom have ever experienced sexual or physical violence).
[161] 2008-2009 KDHS, *Supra* note 24, at 253.
[162] *See* KDHS 2014 SUMMARY, *supra* note 26, at 59, tbl. 3.40.
[163] *See id.* at 60.
[164] CONST. REPUB. KENYA, 2010, art. 29 (c), 53 (1) (d); s*ee also* The Sexual Offences Act, No. 3 (2006) KENYA GAZETTE SUPPLEMENT No. 52, *available* at http://www.urpn.org/uploads/1/3/1/5/13155817/sexual_offences_act_1.pdf.

[165] *See id.*; *see* CESCR Committee, *Concluding Observations: Kenya*, para. 22, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[166] UNICEF, HIDDEN IN PLAIN SIGHT: A STATISTICAL ANALYSIS OF VIOLENCE AGAINST CHILDREN 77 (2014), http://files.unicef.org/publications/files/Hidden_in_plain_sight_statistical_analysis_EN_3_Sept_2014.pdf [hereinafter HIDDEN IN PLAIN SIGHT].
[167] KNCHR REPORT 2012, *supra* note 40, at 82–83.
[168] *Id.* at 88.
[169] INTERNATIONAL RESCUE COMMITTEE (IRC), MY ACTION COUNTS: AN ASSESSMENT OF GENDER BASED VIOLENCE RESPONSES IN NINE COUNTIES IN KENYA 12, 31 (2014) [hereinafter IRC, MY ACTION COUNTS, http://www.rescue.org/sites/default/files/resource-file/My%20Action%20Counts-Consolidated%20GBV%20Assessment%20Report%20in%20Nine%20Counties%20of%20Kenya.pdf; INSTITUTE OF ECONOMIC AFFAIRS - KENYA, STATUS OF GENDER DESKS AT POLICE STATIONS IN KENYA: A CASE STUDY OF NAIROBI PROVINCE iii (2009), *available at* http://www.ieakenya.or.ke/publications/doc_download/49-status-of-gender-desks-at-police-stations-in-kenya
[170] *Id.* at 83.
[171] *See* IRC, MY ACTION COUNTS, *supra* note 169, at 37–41.
[172] *See* Katy Migiro, *One Third of Kenyan Girls Subjected to Sexual Violence - Survey*, REUTERS (Nov. 28, 2012), http://www.trust.org/trustlaw/news/one-third-of-kenyan-girls-subjected-to-sexual-violence-survey (last visited July 6, 2015) [hereinafter Migiro, *One third of Kenyan girls*]; UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA: FINDINGS FROM A 2010 NATIONAL SURVEY 2 (2010).
[173] This information was not disaggregated into male and female statistics. *See* Migiro, *One third of Kenyan girls*, *supra* note 2172; *see also* HIDDEN IN PLAIN SIGHT, *supra* note 166, at 85.
[174] *Id.*, at 85.
[175] S*ee* Migiro, *One third of Kenyan girls*, *supra* note 166.
[176] 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 ET AL., VIOLENCE AGAINST CHILDREN IN KENYA: FINDINGS FROM A 2010 NATIONAL SURVEY 129, tbl.7.2.1. (2012), *available at* http://www.unicef.org/esaro/VAC_in_Kenya.pdf [hereinafter VIOLENCE AGAINST CHILDREN IN KENYA]
[177] *See id.* at 51; *see also* Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION (Nov. 1, 2009), *available at* http://allafrica.com/stories/200911020402.html (last visited July 6, 2015).
[178] VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 176, at 51.
[179] 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), *available at* http://kenyalaw.org/caselaw/cases/view/109721/.
[180] *Id.* paras. 111–12, 123.
[181] *Id.* paras. 123, 132–33, 150.
[182] *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.
[183] W.J. & Another, (2015) eKLR, para. 179.
[184] *Id.*
[185] WHO, *Female Genital Mutilation: Fact Sheet No. 241* (2014), http://www.who.int/mediacentre/factsheets/fs241/en/ (last visited July 6, 2015).
[186] *Id.*
[187] *Id.; see also* CAT Committee, *Concluding Observations: Kenya*, para. 26, U.N. Doc. CAT/C/KEN/CO/2 (2013); Human Rights Committee, *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/C/KEN/CO/3 (2012); CEDAW Committee, *Concluding Observations: Kenya*, paras. 17–20, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); CRC Committee, *Concluding Observations: Kenya*, paras. 53–54, U.N. Doc. CRC/C/KEN/CO/2 (2007).
[188] CESCR Committee, *Concluding Observations: Kenya*, para. 23, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[189] *See* CAT Committee, *Concluding Observations: Kenya*, para. 26, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[190] Kenya Periodic Report 2013, *supra* note 26, at para. 101.
[191] *See* KDHS 2014 SUMMARY, *supra* note 27, at, 61, tbl.3.42.