Committee on the Elimination of All Forms 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

Date: 22th September 2017

RE: Supplementary information on the Kenya State report for Consideration by the Committee on the Convention on the Elimination of All Forms of Discrimination against Women at the 68th session.

Distinguished Committee Members,

Introduction

This submission responds to the Republic of Kenya's Eighth periodic report and the List of Issues raised by the Committee. This submission was prepared by non-governmental organizations working on sexual reproductive health rights (SRHR) across Kenya namely Network for Adolescents and Youth of Africa (NAYA Kenya), Ipas Africa Alliance, Trust for Indigenous Culture and Health (TICAH) and Right Here Right Now Platform in Kenya (RHRN Kenya)

This submission addresses the following issues;

- Constitutional and legislative framework and harmonization of laws
- Stereotypes and harmful practices
- Gender based violence against women
- Health
- Rural women
- Recommendations and proposed questions to the State

Article 1 & 2 - Definition of Discrimination Against Women

A. Constitutional & legislative framework and harmonization of laws on abortion

Kenya ratified the CEDAW on 9th March 1984, therefore it forms part of the laws of Kenya and this is enunciated by the Constitution under Article 2(5) & (6) that stipulates;

(5) The general rules of international law shall form part of the law of Kenya.

(6) Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution.

Therefore, CEDAW forms part of the Kenya law and has validity, enforceability and legitimacy under Kenyan Law.

The Convention defines discrimination against women as "*...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.*"

The Constitution of Kenya, 2010 under Chapter Four on the Bill of Rights elucidates a variety of options for citizens to pursue their rights. However, this gain is being slowly diminished due to the punitive subsidiary laws that tend to limit the exercise of a citizen's right. The progressive realization of women's rights is paramount for any nation that seeks to empower its people. Generally, sexual reproductive health rights for women cannot be under estimated or overemphasized since they are integral in the full realization of women's rights.

One way women's rights are infringed is through discrimination, which affects their access to essential services such as reproductive healthcare. The other way is through lack of safe abortion services, which is fundamental to women's sexual reproductive health and rights. Safe abortion is permitted by the Constitution of Kenya 2010, Art. 26(4), if, in the opinion of a trained health professional, there is need for emergency treatment, or if the life or health of the mother is in danger or if permitted by any other written law.

In 2013, a study carried out by the Ministry of Health, the African Population and Health Research Centre et al titled the *Incidence and Complications of Unsafe abortion in Kenya* was launched. This study revealed that 465,000 abortions occurred in Kenya in 2012, translating to one of the highest national abortion rates in the world. The study showed that 120,000 women received care in health facilities for complications from unsafe abortion, and that more than three-quarters of those treated had moderate or severe complications. Further, young women aged 19 and younger were disproportionately affected.

In light of the provision in the Constitution alongside the data on the magnitude of unsafe abortion in Kenya, the Ministry of Health developed the *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya* (S&Gs). The Guidelines were launched in 2012 and utilized for the provision of quality comprehensive abortion care. However, the Ministry of Health through a letter dated 3rd December 2013 withdrew the Standards and Guidelines and the subsequent memorandum dated 24th February 2014 prohibited training of health care providers on Comprehensive Abortion Care. This has continued to create confusion on service

provision as different counties in Kenya are interpreting it liberally and others are interpreting it restrictively as a complete ban on the provision of safe and legal abortion.

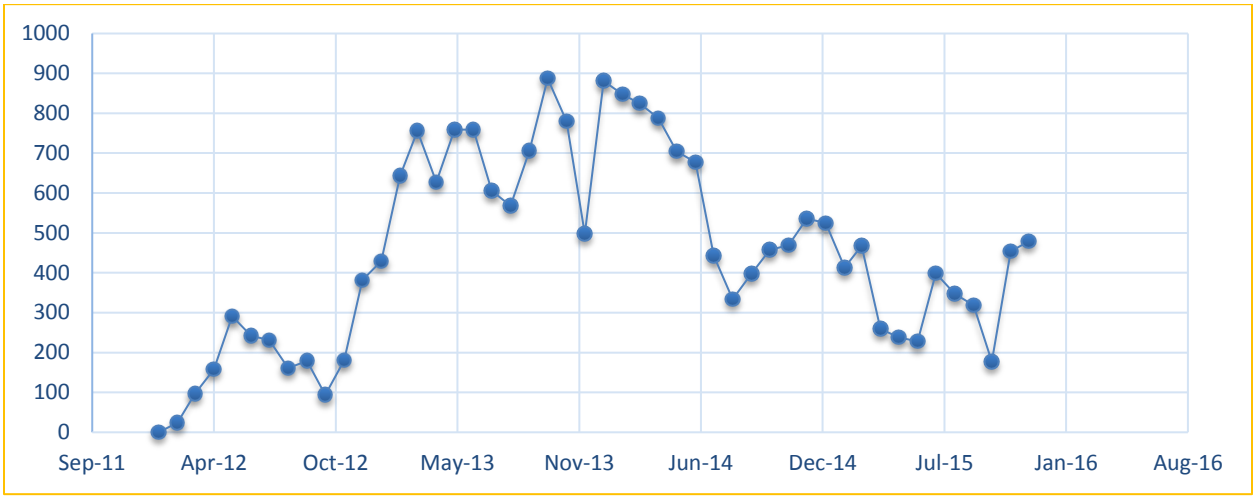

Figure 1: Less women accessed safe abortion after the withdrawal of the Standards and Guidelines, IPAS,

With this prevailing environment, there is ambiguity in Kenya with regard to ratified treaties forming part of Kenyan law. This is the case with the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa popularly referred to as the "Maputo Protocol". When ratifying the Maputo Protocol Kenya placed a reservation on Article 10 and Article 14(2)(c) of the Protocol. These provisions of the protocol stipulate reduction of Government resource allocations to military spending in favor of spending on social development in general, and the promotion of women access to safe abortion services. The ambiguity posed in this regard is that the reservation to the Protocol was put in place at the time of the ratification of the Protocol, which was before the promulgation of the Constitution of Kenya, 2010. Stakeholders have called on the Government through the Attorney General to clarify the status of the reservation to the Protocol to no avail.

These restrictive provisions violate Article 2(f) of the CEDAW Convention, which requires State Parties to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women." Furthermore, CEDAW General Recommendation 24 on Women and Health states, "When possible, legislation criminalizing abortion should be amended, to withdraw punitive measures imposed on women who undergo abortion."

In addition, Section 158 & 160 of the Penal Code of Kenya are inconsistent with the **General Comment 22 on the right to sexual and reproductive health** under article 12 of the Covenant on Economic, Social and Cultural Rights, CESCR, has stated that the "right to sexual and reproductive health is an integral part of the right to health enshrined in article 12" and full enjoyment of this right is often limited by a number of

legal, procedural, practical, and social barriers.[1] Specific to abortion restrictions, the General Comment notes that denial of abortion services often contributes to increased maternal mortality and morbidity, constituting a violation of the right to life or security, and sometimes amounting to torture or cruel, inhuman or degrading treatment.[2] General Comment 22 also calls for the repeal or reform of discriminatory laws, policies and practices in the area of sexual and reproductive health, *including liberalization of restrictive abortion laws*, as well as the removal of all barriers that interfere with access by women to comprehensive sexual and reproductive health services, goods, education and information.[3]

The Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14 on the right to health, specifies that states must implement measures to "improve child and maternal health, sexual and reproductive health care services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as resources necessary to act on that information." From the 2016 CESCR Kenya Review the CESCR Committee noted;

53. The Committee is concerned at the criminalization of abortion under any circumstance provided in the Penal Code, the large number of unsafe abortions and the consistent high rate of maternal mortality. It is also concerned at cases of post-delivery detention of women unable to pay their medical bills in health care facilities. It is further concerned at the limited access to sexual and reproductive health information and services as well as contraceptives, especially for women living in rural areas (art. 12).

54. The Committee recommends that the State party 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.' It also recommends that the State party take concrete measures to ensure free maternal healthcare services and to prevent the incidence of post-delivery detention in health care facilities. It further recommends that the State party strengthen its efforts to improve access to sexual and reproductive health information and services, including to contraceptives. In this regard, the Committee draws the attention of the State party to its general comment No. 22 on the right to sexual and reproductive Health.

It is our submission that there is a lackluster approach by the Kenya government to amend or repeal the Penal code thereby decriminalizing abortion in Kenya. This is a serious affront to the laid down international guidelines on health as well as the rights of its citizens especially women.

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[1] CESCR, *General Comment 22: The Right to Sexual and Reproductive Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (May 2016), pars. 1-2.
[2] *Id.* at par. 12.
[3] *Id.* at par. 28.

The Health Act 2017 which was assented to by the President on 21st June 2017 establishes a unified health system to coordinate the inter-relationship between the national and county governments health systems. It was also enacted to define how national health policy shall be formulated, implemented and coordinated between the two levels of government. However, the Health Act infringes on the sexual reproductive rights of women. Under section 6 1(c) of the Act, provides that[4]:

"Every person has a right to reproductive healthcare which includes – access to treatment by a trained health professional for conditions occurring during pregnancy including abnormal pregnancy conditions, such as ectopic, abdominal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened. All such cases shall be regarded as comprising notifiable conditions."

The inclusion of pregnancy related conditions as notifiable conditions, like would be with Cholera or Ebola under the Public Health Act of Kenya is vague and confusing to both the health care practitioners and the public because the Public Health Act deals with "*notifiable diseases*". The pregnancy complications defined in this section are neither abnormal, nor are they transmissible or communicable.

The definition as stands would further stigmatize reproductive health services and could deter patients from seeking services and providers from providing them. However, it is noted that section 6 (1) (c) does not speak about abortion specifically. The lack of clinical guidance on the provision of safe abortion services creates a gap and the use of the terms "*exacerbated by the pregnancy*" in the Health Act may be misconstrued to include "abortion" as a notifiable condition.

B. Discrimination against lesbian, bisexual and transgender women

The Constitution of Kenya in Article 27 (4) guarantees individuals the right not to be discriminated against, directly or indirectly, on any grounds. However, lesbian, bisexual and transgender women still experience discrimination and violence from state and non-state actors and agencies. This situation is further enabled by the Penal Code in Sections 162, 163 and 165 that criminalizes same sex relationships thus further entrenching discrimination on actual or perceived sexual orientation and or gender identity.

In its Concluding Observation to Croatia, the CEDAW Committee noted with concern the discrimination, including by the judiciary and law enforcement personnel, against lesbian, bisexual and transgender women, in addition to the inadequacy of measures taken to combat hate speech against them, including the tendency to prosecute such offences under misdemeanor law rather than hate crime provisions. In his first thematic

[4] The Health Act.

report to Human Rights Council, the United Nations Independent Expert on Discrimination due to Sexual Orientation and Gender Identity writes that, "laws and policies that criminalize consensual same-sex relations are part of the background environment that leads to violence and discrimination." [5]

In line with the universality, inalienability, indivisibility, interdependence and interrelatedness of human rights, discrimination of women based on their sexual orientation and gender identity further denies them other rights including access to justice, health, dignity, assembly, association and right to self-determination among others. In his report, the Independent Expert continues that the preferred approach should be to ensure access to comprehensive health care for all, without resorting to labels that give rise to stigma. The invitation to destigmatize and de-pathologize opens the door to more cooperation with the medical, scientific and ethics sectors, to promote shared understanding that sexual orientation and gender identity are part of the natural state of being human, and correlatively, to ensure respect for all persons without distinction.

During the second Universal Periodic Review cycle[6], Kenya accepted a recommendation to adopt a comprehensive anti-discrimination law affording protection to all individuals, irrespective of their sexual orientation or gender identity, which was in line with Article 27 (6) to take legislative and other measures including affirmative action programs and policies to redress disadvantages due to past discrimination. This will go a long way in eliminating discrimination against women due to sexual orientation and gender identity.

Proposed questions for the Government of Kenya:

- *What steps has Kenya taken towards lifting the reservation on the Maputo Protocols Article 14 (2) c?*
- *What steps has Kenya taken towards amending or repealing the Penal Code Sections 158,160,162,163 & 165?*
- *What steps has Kenya taken towards reinstating and disseminating the Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya?*
- *What steps is Kenya taking towards providing regulations on what a notifiable condition is as stipulated by the Health Act, 2017?*
- *What steps is Kenya taking to develop a comprehensive anti-discriminatory law due to Sexual Orientation and Gender Identity in line with the Universal Periodic Review Accepted Recommendation*
- *What is Kenya doing to develop a subsidiary law in furtherance to Art 26 (4) of the constitution to ensure access to safe and legal abortion.*

[5] UN Independent Expert on Sexual Orientation and Gender Identity Report to HRC Report https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/095/53/PDF/G1709553.pdf?OpenElement

[6] UPR Recommendations https://www.upr-info.org/database/

B. **Article 5 - Stereotypes and harmful practices**

Despite the right to protection from harmful practices being a right guaranteed in the Kenya Constitution, many women and girls continue to undergo stereotypes and harmful practices. The National Adolescent Sexual and Reproductive Health Policy 2015, recognizes that some harmful practices are rooted in traditional attitudes while others evolving around modern times have a direct impact on health, including reproductive health, education, mortality, and lists reducing harmful traditional practices as one of priority areas for intervention

Traditional harmful traditional practices such as Female Genital Mutilation (FGM), Child, Early and Forced Marriages and beading of girls (a silent harmful practice in Samburu Kenya) continues to rob girls' access to education. According to the beading tradition[7], warriors (Morans) are allowed to have a temporary marital relationship with very young girls (as young as 7years) from the same clan as the warrior. The Moran buys red beads for the girl after getting the mandate from the family of the girl. The main objective of the beading is to prepare the young girl for marriage in future. Since the Moran and his beaded girl are relatives, and the girl is uncircumcised, both marriage and pregnancy are forbidden. In the case a girl does become pregnant, the pregnancy is terminated through an abortion induced by elderly women of the clan. They squeeze the girl's stomach and force her to drink herbs until the pregnancy is terminated. If the beaded girl gives birth, the child is killed through herbs poisoning, since the child is perceived to be an outcast. The babies who survive are given out to other communities like the Turkana tribe. In addition to life threatening early pregnancies and abortions, the practice of beading exposes young girls to physical, mental and sexual violence. There exist no proper statistics on the vice due to the stigma of the practice, however Samburu Women Trust conducted a desk review in Samburu, Marsabit and Laikipia counties and found that over 755 girls had been beaded over the past two decades, translating to 3 girls every month.

Historically all but five of Kenya's 43 ethnic groups practiced FGM/C. The estimated prevalence of the practice has declined from 38 percent in 1998 to 21 percent in 2013 as per the Kenya Demographic Health Survey (KDHS) of 2014, with growing awareness and campaigns to end the harmful practice, including the passage of the Prohibition of Female Genital Mutilation Act, 2011. However, despite the adoption of the law, Kenya

[7] http://www.ngeckenya.org/Downloads/SWT%20Girl-Child%20beading%20Research%20in%20(Laikipia,%20Samburu%20and%20Marsabit)%20Counties.pdf

has experienced a new trend of FGM/C, namely a medicalized form of FGM/C that is performed by health providers.

The World Health Organization defines medicalization of FGM as "*the situation in which FGM/C is practiced by any category of health-care provider, whether in a public or private clinic, at home or elsewhere.*" In some countries, there are certain procedures, such as re-infibulation, that have become medicalized. According to the UNFPA-UNICEF Joint Programme on FGM/C Annual report of 2010, "*FGM/C is being increasingly medicalized and supported by some medical practitioners in countries such as Kenya, Ethiopia, Somalia, Guinea, Sudan and Egypt.*" This hinders the progress that has been made so far in ending FGM/C in Kenya. There is need for more qualitative research to study the attitudes and beliefs of health care providers, especially those who practice FGM/C, to see what forces are driving them to perform this procedure and appropriate policy and legal measures developed and implemented.

Child Early and Forced Marriages (CEFM) is linked to FGM/C and beading of girls. According to the Kenya Demographic Health Survey (KDHS) 2014 23% of girls are married before the age of 18. CEFM varies in most regions in Kenya, with some regions like North Eastern and Coast regions recording the highest prevalence rates and Nairobi and Central recording the lowest rates of CEFM. Community attitudes towards these cultural harmful practices hinder efforts in ending them. The Government should play a major role in enforcing and implementing existing policies, preventing new cases of CEFM through awareness creation, and prosecuting perpetrators of harmful practices.

Proposed recommendation and questions for the Government of Kenya:

- *What measures is Kenya taking towards strengthening capacities of institutions such as the Anti FGM Board and communities as well as encouraging male involvement as and supporting implementation of appropriate policies and programs and enforcement of laws?*
- *What measure is Kenya taking towards setting clear guidelines on the implementation matrix, of how the Ministry of Health will collaborate with the FGM Board as a key institution on harmful practices?*
- *Kenya to increase budgetary allocation to eradicating harmful practices including FGM in line with Program Based Budgeting.*

C. **Gender based violence against women**

Gender based violence against women and girls presents as a persistent issue in Kenya and has reached high levels. The persistence of certain cultural norms, traditions, and stereotypes perpetuates violence against women and girls in Kenya. Gender based violence is a human rights violation and young women and girls need strong measures to end it through prevention programs, legislation and access to justice.

An emergent crisis is the high statistics for incest, marital rape that leave women in a vulnerable position. Kenya National Bureau of Statistics indicates that almost half (45%) women age 15-49 have ever experienced physical violence since age 15. Twenty percent of women have experienced physical violence in last 12 months. Divorced/separated/ widowed women are most at risk: 64% of divorced women report having ever experienced violence since age 15 compared to 32% of never-married women. Among ever-married women, the most common perpetrators of violence are current or former husbands and partners. Among the never-married women, mothers/step-mothers and fathers/stepfathers are the most common perpetrators. A similar proportion of men age 15-49, (44%) report that they have experienced violence since age 15, but fewer (12%) have experienced it in the last year. Men rarely report that wives or partners are the perpetrators of the violence.

Furthermore 14% of women age 15-49 have ever experienced sexual violence; 8% have experienced sexual violence in the past year. Fewer men 6% report having ever experienced sexual violence. More than one-third of ever-married women report that they have experienced physical violence by their husband or partner. An additional 32% report emotional violence, and 13% report sexual violence. There are regional variations in reports of spousal violence. For instance, 50% of women in Nyanza report spousal violence (physical or sexual) compared to only 10% of women in North Eastern. Seven percent of married men report that they have experienced physical violence by their wife/partner. An additional 4% report sexual violence, while 21% of married men experience emotional abuse by their spouse.

Violence during pregnancy may threaten not only a woman's wellbeing but also her unborn child. Nine percent of women age 15-49 who has ever been pregnant experienced violence during pregnancy. Violence during pregnancy is especially high among women in Nairobi (18%) and among divorced/ separated/widowed women (21%).

The Government is lax in preventing and protecting women and girls. The reporting mechanisms for survivors of sexual violence are still questionable and the government investment is still low. In the efforts of curbing and addressing Gender Based Violence, Kenya came up with a Multi-Sectoral and holistic approach through incepting of one-

stop center to offer services at the hospital level. The services are free of charge supported by qualified multi-disciplinary team that provide counseling services, legal aid and economic empowerment as well as preserve forensic evidence to help the survivors' access justice.

The inception of one stop centers in Kenya at the Kenyatta and Mbagathi hospital was seen as a major measure to help women and girl survivors of gender based violence in seeking justice and healing. As government health institutions, this was anticipated as one of the measures that will work. However, per an evaluation done by Population Council it states that survivors of gender-based violence seek services to Non-Governmental Organizations first before going to the center. While this should be government responsibility to ensure the center is fully equipped and have adequate staff, it is the NGOs that have put more concerted efforts aimed at ending violence against women.

The lack of safe houses in Kenya continues to put women in the hands of perpetrators of violence, as they do not have safe havens for shelter. More safe spaces must be provided in communities including shelters and support to survivors. Violence against women has a cost to the economic and health status of the family and to address this the government must fight impunity at all levels.

Further, limited information and the gaps in reporting and prosecution also perpetuates fear and stigma. The government needs to strengthen public education programs on women rights and other interventions on protection against domestic violence. The investigating institutions (police) need to be well equipped to investigate the various complaints raised to them.

Women and other vulnerable groups not only continue to be more vulnerable to violence, including sexual and gender based violence, during peaceful times, but also during political and civil unrest. In its preliminary report on the Kenya 2017 elections, the Kenya Human Rights Commission, through the Kura Yangu Sauti Yangu Initiative, confirm three reports of rape by state agents while quelling demonstrations and unrest after the August 2017 Presidential Polls were announced. The Kenya National Commission on Human Rights, KNCHR, in its preliminary report noted allegations of General Service Units forcefully entering people's homes and beating them up well as threatening them with rape.

Proposed recommendations to the Government of Kenya:

- *Development of government owned safe houses for survivors of violence against women and girls*
- *Strengthening of the one stop center to offer quality services and response to survivors of violence against women*
- *Funds allocation in the fight to end GBV*
- *Fast and proper prosecutions of perpetrators of violence against women*

D. **Article 12 - Health**

The Constitution of Kenya, in Article 43 (1), guarantees every individual the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care.

However, Kenyan women continue to experience violation of their rights including inadequate access to services contributing to high incidences of maternal morbidity and mortality. According to the Ministry of Health's National Guidelines for Maternal and Perinatal Death Surveillance and Response, about 16 women die every day from pregnancy and childbirth complications. Whereas the government has introduced the free maternity program, its implementation and effectiveness have not been felt by women in Kenya who seek such services. There are reports of inadequate equipment and materials, hidden charges and several reports of women detained for being unable to pay.

There is also the beyond zero campaign which is a good initiative. However, the mortality rate is still high and the main concern has been the growing numbers of unsafe abortions as a number one cause of death. This can be attributed to the fact that both programs do not provide contraceptives and post abortion care. Unsafe abortion related deaths are ranked number two after post-partum hemorrhage There is need for the government to further fund these initiatives to cater for more services that improve the sexual reproductive rights of women.

In the community-based work done by non-profit organizations in Kenya experiences are shared by women on the challenges they face in accessing health care particularly reproductive health services.

Case study on the violation of the right to safe abortion care[8]

"In December 2013, while most Kenyan school children were celebrating school being out for the holidays, one 14-year-old Kenyan girl found herself in a desperate situation. After being coerced by an older man into her first sexual relationship, she discovered she was pregnant and feared she would be blamed and rejected by her family if she were to reveal her condition.

Living away from home in order to attend a good school, Wanjiku turned to a friend, an older girl, for advice on how to end the pregnancy. The older girl knew of someone nearby who could help. This is how Wanjiku found herself doing what hundreds of thousands of women in Kenya are forced to do each year: seeking abortion care from an unqualified provider.

Two days after seeking an abortion from a "doctor" in the backroom of a local pharmacy, she began vomiting and bleeding heavily. She was taken to a hospital where she was found to be experiencing kidney failure. After she was stabilized, she was detained by the hospital because her mother—a poor tea picker—could not pay the hospital bills. There, Wanjiku was forced to sleep on a mattress on the floor, where her health again deteriorated. Her life will never be the same. "

According to the World Health Organization[9], there is evidence that many young people regard health services as irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate. They require services that are in the right place, at the right time, at the right price (free where necessary) and delivered in the right style to be acceptable by them. However, per the Kenya Service Availability and Readiness Assessment Measure[10], nationally, only one out of ten of public health facilities provide comprehensive youth friendly services. Young women and girls are thus limited in accessing healthcare information and services including contraceptives. This is manifested in frequent stock outs and inadequate human resource for health.

[8] https://www.reproductiverights.org/feature/keep-wanjiku-safe
[9] http://www.who.int/maternal_child_adolescent/documents/fch_cah_02_14/en/
[10] http://apps.who.int/healthinfo/systems/datacatalog/index.php/catalog/42

This is further aggravated by inadequate service providers, poor attitudes towards women's sexual and reproductive health rights. There is an urgent need for training on youth and women friendly services.

Despite Kenya being a signatory to the Abuja Declaration where nations committed to allocating a minimum budget of 15% to health, budgetary allocation to health remains inadequate; 7.5% in FY 2014/2015, 7.7% in FY 2015/2016 and 7.6% in FY 2016/2017. [11]

Kenya is also a party to the East and Southern Africa Ministerial Commitment on Provision of Comprehensive Sexuality Education[12], Kenya has still not fully integrated age appropriate comprehensive sexuality education in the school curriculum. Young people are thus not able to access accurate and evidence based information about human sexuality at school, parents and religious leaders remain straitlaced on issues of sexuality at home, thus limiting the young people to unverifiable and sometimes grossly misleading misinformation from peers and the internet. Google Zeitgeist results reveals that how to use a condom, what is sex, how to abort, what is HIV/AIDS have been some of the most asked questions online in the recent years.

The Kenya Health Policy 2014-2030, stresses the importance of inclusiveness, non-discrimination, social accountability, and gender equality in provision of health services. However, transwomen, lesbians and bisexual women still face hurdles to enjoying their constitutional right to the highest attainable standard of healthcare. Per a report by UHAI – the East African Sexual Health and Rights Initiative, about 4 out of 10 LGBTI persons in East Africa responded that they were denied health services because their gender identity with 46% responding that they were denied services due to their sexual orientation. Further, about 4 out of 10 respondents (37.44%) confirmed staying away from health services due to their sexual orientation.

Per the World Health Organization, in settings where same-sex consensual sexual behavior is against the law, people may be deterred from seeking health services out of fear of being arrested and prosecuted.

Questions and recommendations to the Government of Kenya:

- What is being done to ensure that health care providers receive training on providing comprehensive abortion care services?
- What measures has the Government put in place to provide remedy and justice for preventable deaths as a consequence of unsafe abortion?
- What measures is the Government putting in place to allocate more resources to healthcare?
- What measures is the Government putting in place to provide age appropriate comprehensive sexuality education to school going children?
- What measures has the government taken to provide comprehensive friendly services and alleviate discrimination in access services to all women including LBT women?
- Strengthen implementation of National Adolescent Sexual and Reproductive Health Policy and Adolescent and Youth Friendly Services through increased budgetary allocation in line with Programme Based Budgeting.

E. **Article 14 - Rural women**

Rural women have inadequate access to sexual and reproductive health care services and information. From early childhood, they are denied nutritious food and leisure activities due to the prevalent 'son preference syndrome', which are vital for health and robust growth. They are married early and due to repeated pregnancies and short birth spacing they face chronic malnutrition. They have inadequate access to antenatal and postnatal care, leading to maternal mortality and morbidity or other complications like pelvic organ prolapsed, obstetric fistula and reproductive tract infections. Lack of women-friendly health services, skilled birth attendance, and female medical practitioners in rural area limit access to contraceptives. Unregulated healthcare services lead to lack of accountability of health care providers.

Rural women's sexual and reproductive health and rights are not recognized. Hence, women lack control over their bodies including their sexuality, decision-making in their marriage (age of marriage, choice of partner), when and whether to have or not to have children. Social and cultural norms prescribed by patriarchy control over rural women's bodies and sexuality resulting in limited mobility, brutal violence including, witch hunting, marital rape, domestic violence, child marriage, exchange marriage, dowry, and sexual violence. Further, Inadequate access to contraceptives and bodily autonomy and integrity also affect disproportionately rural women.

Per the Kenya Health Demographic Survey 2014 report[13], the fertility of a rural woman is one more than the urban one, in rural areas, 4 in 10 households spend 30 minutes or more to obtain their drinking water, as compared with only 1 in 10 urban households, Domestic violence is also higher (45.3% as compared to 43.9%). This is contrary to CEDAW general recommendation no. 19 on violence against women.

The unmet need for contraceptives is higher in rural areas (20%) than urban areas (13%). Unmet need decreases with education: 28% of women with no education have an unmet need for family planning compared to 12% of women with secondary or higher education. Unmet need also decreases with household wealth.

All women work - whether paid or unpaid. Women, especially rural women, do a lot of unpaid work within the household and do agriculture work in family farms and enterprises. Despite its obvious economic and social worth, much of the work that women do remains invisible, undervalued, and under-appreciated, and is not included in GDP. Women do most of household, and care work. They spend many hours in collecting water, fuel and fodder, cooking, cleaning, domestic chores, repair and

[13] KDHS 2014, https://dhsprogram.com/pubs/pdf/FR308/FR308.pdf

maintenance of house. This work is backbreaking, time-consuming and is not shared by men. It puts an unequal burden on women and prevents them from participating in productive work in the labor market. Lack of infrastructure, poor energy and technology options add to this burden.

Recommendations to the Government of Kenya:

- *Allocate more resources to county governments to build more hospitals and healthcare facilities.*
- *Community education and sensitization on their right to highest attainable healthcare.*