CENTER FOR REPRODUCTIVE RIGHTS

Committee on Economic, Social and Cultural Rights
Human Rights Treaties Division
Office of the United Nations High Commissioner for Human Rights
Palais Wilson- 52, rue des Pâquis
CH- 1201 Geneva (Switzerland)

February 1, 2016

Re: Supplementary Information on Kenya, Scheduled for Review by the Committee on Economic, Social, and Cultural Rights during its 57th 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 57th 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 detention, abuse and mistreatment of women seeking maternal health care services; inaccessibility of safe abortion services and post-abortion care; lack of access to comprehensive family planning services and information; and 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

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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 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 care 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

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]

However, the World Health Organization's (WHO) 2015 report found that Kenya's maternal mortality rate (MMR) had only decreased by 1.2% per year since 1990—well short of the target rate of 5.5%—and that Kenya had not achieved its Millennium Development Goal target MMR of 175 deaths per 100,000 live births which it had committed to achieve by end of 2015.[22] According

to the same report, 510 Kenyan women and girls die per every 100,000 live births,[23] which is an increase from the MMR of 400 death per 100,000 live births documented in the 2013 version of the same WHO report.[24] The Committee in the List of Issues (LOIs) asked the government to **"explain why the maternal mortality rate has increased"** and to indicate **"measures taken to reverse this alarming trend and on the impact of those measures."[25]** Similarly the government, in its current report to the Committee, stated that the "declining maternal health indicators are worrying."[26]

Part of this increasing trend in the MMR can be attributed to the significant challenges women and girls, particularly low-income women, women with lower levels of education, and those in rural areas, encounter in accessing quality maternal health care services. According to the 2014 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 attended 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]

In its response to the LOIs on maternal mortality, the government stated that "[f]ree maternity services introduced by the government have helped reduce the number of unskilled deliveries which in many ways have been the biggest contributor of the maternal deaths."[31] Although free maternity services were introduced in 2013 through a Presidential Directive, women continue to face challenges in obtaining quality delivery care; access to skilled providers during delivery is markedly worse for lower income, less educated, and rural women.[32] 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.[33] 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.[34] Further, while the WHO recommends postnatal care starting an hour after giving birth for the first 24 hours in order to check for complications,[35] only 51% of women receive a postnatal checkup within two days of giving birth.[36] 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.[37] 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."[38]

In recent years, the Kenyan government has made some efforts to address these issues. For example, in June 2013, the government issued a Presidential Directive which provided that all pregnant women would be able to, "access free maternity services in all public health facilities."[39] Nevertheless, as described below, implementation of this Presidential Directive remains a challenge. In addition, in January 2014, the First Lady of Kenya spearheaded the Beyond Zero Campaign to raise awareness about the link between good health and a strong nation, specifically demonstrating the importance of maternal, newborn, and children's health.[40] The Campaign has delivered thirty six mobile clinics since its inception.[41] However, as the First Lady has stated, "the initiative alone cannot bring about success. Success requires all actors in the health sector especially county governments to expand this program to every corner" of Kenya.[42] Indeed, the increasing MMR shows that the government needs to scale up its efforts to ensure all pregnant women have access to comprehensive maternal health services.

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

As result of a fact finding report conducted by the Center and FIDA- Kenya, which revealed that women who attend maternal health care services are frequently neglected and encounter systematic abuse from health care professionals and staff,[43] the Committee, during the review of Kenya in 2008, recommended the state take measures to ensure that all women have "access to skilled care free from abuse during pregnancy, delivery, postpartum, postnatal periods."[44] However, violations of the rights of women and girls attending maternal health services including abuse and detention has continued. For instance, at a focus group discussion which the Center and the Kenya Network of Grassroots Associations organized in 2012, 23 of the 26 women who participated in the discussion, stated that they were detained after giving birth for not paying their bills at Pumwani Maternity Hospital (Pumwani), which is the largest hospital in Kenya.[45] Most of the women were detained for durations of between two weeks and two months.[46] The majority of them also reported that they were not released until after someone paid the hospital fees on their behalf or advocacy groups intervened.[47] One woman was detained for nine months with her baby and was not released until she went on a hunger strike.[48] 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."[49]

Most women who are detained are denied post-natal and other crucial medical care. For instance, one woman was denied care even though her surgical wounds were bleeding.[50] Another woman reported being subjected to "abusive and frustrating statements."[51] The detained women— whose newborns are most often also detained with them—are not provided with basic necessities: one casual worker in a district hospital, in describing the situation of women detained in the hospital, revealed that at times three women were forced to share one bed since all the beds were occupied and women who had been detained for a long time had to struggle to get food.[52]

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.[53] For instance, women are often barred from entering the hospital if they are unable to afford the admission fee.[54] 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.[55] In many instances, as mentioned above, 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.[56] The internal and external mechanisms through which women can get redress for these violations of their human rights are ineffective.[57] Even when redress mechanisms are available, women often do not know about them or lack the necessary information about how to access them.[58]

These findings were further documented in a 2012 national public inquiry by the Kenyan National Human Rights Commission (KNHRC).[59] 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.[60] The women interviewed for the research conducted by the Center recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[61] 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.[62]

In response to these egregious actions, the Center filed a case on behalf of two women in the High Court of Kenya in 2012 highlighting the abuse women face at health care facilities and seeking declaration that this treatment amounts to a violation of their human rights.[63] 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.[64] Due to the delay in emergency care, her bladder ruptured after her caesarean section.[65] Her suffering was compounded by the fact that her wound was infected and the stitching had been poorly performed.[66] 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.[67] On September 17, 2015, the Court passed a decision and found that the rights of the petitioners, 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. Accordingly, it is vital for the government to implement this judgment and ensure that women are no longer detained in maternal health facilities but rather receive quality and respectful maternal health care.

Inadequate implementation of presidential directive on free maternity care

As noted above and in Kenya's current report,[68] 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."[69] 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,[70] and the government has failed to allocate sufficient additional resources to remedy this issue.[71] 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.[72] In fact, on October 21, 2015, Nairobi's County Governor, Dr. Evans Kidero, abolished free maternity care at the PMH, Kenya's largest public maternity hospital, due to the national government's failure to reimburse Nairobi KES165 million spent covering maternity services over the past nine months. [73] A number of other counties also complained that the national government was slow in distributing reimbursements for free maternity services.[74]

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.[75] Women still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.[76] Other key components of maternal health services, including antenatal and postnatal care, are also not covered under the directive.[77] Further, the Reproductive Healthcare Bill that was tabled in parliament provides for free antenatal care,[78] 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.[79] 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.[80] 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.[81]

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

During the 2008 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."[82] The committee on the Elimination of Discrimination against Women (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."[83] 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.[84] In the LOIs, the Committee asked the government to **"provide information on the incidence of illegal abortions and the measures contemplated to address resulting problems."**[85]

Although the government has not responded to this question, research shows that, in Kenya, unsafe abortion accounts for one-third of maternal deaths[86] which can be due to the numerous barriers women face in accessing safe abortion services. For instance, 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,[87] the Penal Code has not been revised to reflect this change.[88] 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.[89] 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."[90] 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 government, in its response to the Committee, stated that the Reproductive Health Bill "provides for the right to make decisions regarding reproduction free from discrimination, coercion and violence,"[91] it merely codifies the health and life exceptions for abortions provided under the Constitution and places unnecessary and likely unconstitutional restrictions on access under these circumstances. For instance, the Bill would require a health care professional to consult the parents or a guardian of an adolescent before providing an abortion where her life or health is at risk,[92] 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.[93] 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.[94] 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.[95] 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.[96] The KNHRC further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya.[97] A 2013 study conducted by the Ministry of Health estimated that nearly 465,000 abortions occur in Kenya each year.[98] Approximately 120,000 women sought care in health care facilities for unsafe abortion-related complications.[99] One study found that up to 60% of all gynecologic emergency hospital admissions are a result of complications from unsafe abortion.[100] It concluded that the numbers of maternal death due to unsafe abortion is high.[101] The harshness of Kenya's abortion laws most heavily impacts young women[102] and low income women—for whom the unintended pregnancy rate is highest[103]—even where relatively safe abortion procedures are available, because the cost of these services often exceeds these women's financial resources.[104] 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.[105] 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.[106]

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.

Post-abortion care

Access to post-abortion care (PAC) is essential to protect the health and lives of women following an unsafe abortion—particularly in Kenya where the rate of unsafe abortion and resulting complications remain high. For example, a hospital in Mombasa received at least 102 patients in need of PAC during a four month period from late 2014 to early 2015.[107] Moreover, a 2015 study found that 77% of Kenyan women seeking PAC suffered from moderate or severe

complications.[108] However, barriers to access to PAC create delays in receiving essential treatment, which cause disproportionately higher rates of severe post-abortion complications.[109]

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 abortion, including harassment by the police and possible prosecution.[110] Although the government has stated that PAC "is legal and not punishable by any part of Kenya laws,"[111] this declaration only offers protection to the health care providers and not to women who seek PAC.[112] 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."[113] These delays can have fatal consequences for women that present with treatable conditions.[114]

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.[115] Medical providers may also make women feel like criminals instead of patients by insulting and shaming them for having undergone abortion.[116] Some medical providers may even not be aware that providing PAC is legal,[117] 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[118]—a predicament medical staff use to extort bribes from patients.[119]

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."[120] 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,"[121] and the recommendation for the government to "ensure affordable access for everyone, including adolescents, to comprehensive family planning services [and] contraceptives. [122] However, Kenya's report, despite acknowledging the Committee's recommendation on family planning, does not discuss the effort the government is making to ensure access to family planning information and services.[123]

According to the 2014 KDHS, only about half of Kenyan women (53.4%) are able to access modern methods of contraceptives,[124] an increase of only seven percentage points from the 2008 rate.[125] 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.[126] The 2014 KDHS found that although women from all demographic backgrounds have significant unmet family planning needs,[127] 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.[128] In addition, usage disparities are even more pronounced by geographic area[129] 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—[130] use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.[131]

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.[132] 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.[133] Moreover, a woman's preferred method of contraception is often unavailable[134] or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members.[135] 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.[136]

In the LOIs, the Committee asked the government to **"provide information on the measures taken to ensure comprehensive knowledge, particularly among adolescents…about… safe sex.**"[137] Apart from stating that adolescents have low knowledge regarding HIV prevention,[138] the government has not provided information about the steps it is taking to increase adolescents' access to reproductive health information. Research shows that social stigma against the use of contraception is particularly problematic for adolescents, who are one of the groups most vulnerable to experiencing discrimination in access to family planning services.[139] 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."[140] Young people in Kenya also lack formal and comprehensive sex education,[141] resulting in misinformation about their reproductive health, including concerns about poor outcomes from using contraceptives.[142] These misconceptions lead to lower contraceptive use rates and a higher incidence of unplanned and unwanted pregnancies.[143]

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.[144] Indeed, the National Guideline on the Management of Sexual Violence in Kenya requires that EC be available 24 hours a day for survivors of sexual violence in all health facilities.[145] In Kenya, nine products of EC are registered,[146] and the Ministry of Health broadly recommends its use for those "who have had unprotected sexual intercourse and desire to prevent pregnancy."[147] The Ministry also has recognized that EC "is an important component of adolescent reproductive health."[148] 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.[149]

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.[150] Some pharmacists also decline to distribute EC altogether or refuse to dispense it without a prescription,[151] although EC is registered in Kenya as an over-the-counter medicine.[152] Despite the Ministry of Health's guidelines that explicitly permit EC's usage for any unprotected sex, arbitrary refusals stem from the perception that the contraceptive is only intended to be used by rape victims.[153] Moreover, adolescents are routinely denied access to EC for arbitrary or discriminatory reasons such as "the person look[ed] young."[154] A 2014 study found out that only 18% of women

and girls surveyed in Nairobi have ever used EC.[155] 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.[156] 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.[157]

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

Gender-based violence has been addressed in many of the concluding observations on Kenya issued by various TMBs.[158] 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."[159] 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 allegation.[160] However, the government also acknowledges that "a number of gender facilitative bills including the marriage bills, have for years remained unlegislated."[161] 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

Previously, the Committee expressed concern regarding the high rate of domestic violence and "the low number of complaints filed by victims.[162] Despite chronic underreporting, data from various sources demonstrate that violence against women, sexual and otherwise, remains prevalent in Kenya. In March 2013, the Gender Minister reported that 32% of females in Kenya have experienced sexual violence.[163] The 2014 KDHS shows that approximately 44% of ever-married women have experienced sexual or physical violence by their husband or partner, [164] which is not a significant decrease from 2008-2009 KDHS where 47% of ever-married women reported to having experienced such violence.[165] In addition, roughly 28% women aged 20-29 had experienced some form of violence in the previous 12 months preceding the survey.[166]

In May 2015, the President signed into law the Protection against Domestic Violence Act[167] which criminalizes a wide range of gender-based violence including marital rape, economic and sexual abuse and harmful traditional practices such as female genital mutilation.[168] It also sets out protection mechanisms for victims, such as counseling and medical assistance, as well as protection orders against the perpetrator.[169] In the LOIs, the Committee asked for information on the **measures the government has taken to enforce the provisions of the Bill.[170]** In response, the government listed some measures it has implemented, such as the establishment of an online Gender Based Violence forum; training of police and chiefs and sensitization of the community; and dissemination of a simplified version of the Act, in an effort to implement it.[171] However, the government also acknowledged that "there is still a lot that needs to be done as the enforcement of this act is still very low."[172] Indeed, the government needs to take concrete steps to ensure the full and effective implementation of the Domestic Violence Act. For instance, it must allocate adequate budget to ensure medical services, including counselling are available to victims.[173] Per the requirement of the Act, the Inspector General must also set up reporting procedures by training of

police officers, facilitate "the reporting process so that complainants may report to the police without fear," and ensure the expedient and efficient processing of complaints.[174]

This is particularly important since survivors of sexual and physical violence often 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.[175] Further, health care providers may lack adequate training or an understanding of the appropriate medical and gender-sensitive response toward sexual violence.[176] 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.[177] Therefore, women and girls who experience violence are subjected to social stigma, humiliation, and bribe requests in police stations.[178] Legal assistance is also not readily available, which makes access to remedies daunting and disincentivizes the use of the legal system for redress.[179]

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.[180] 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.[181] Of those who had experienced violence, six out of ten have been physically abused.[182] Rape is rarely reported as a result of pervasive social stigma and a deep mistrust in police and the criminal justice system.[183] A 2012 UNICEF study determined that only 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.[184] Sexual violence against girls and adolescents is also a significant problem in schools and other educational settings. According to the same UNICEF study, from the women aged 18 to 24 who experienced unwanted sexual touching before the age of 18, about 25% reported that the first incident took place in school.[185] 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.[186]

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.[187] In a decision passed in 2015, the High Court of Kenya 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.[188] Although the TSC circular, or employee guidelines, mentions disciplinary action for the sexual assault of students,[189] the circular fails to indicate clear mechanisms for disciplinary action or provide sexual assault survivors with psychological or essential health care.[190] The Government of Kenya must ensure that the TSC complies with the 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."[191] The Government must also follow the Court's order to "put in place an effective mechanism"[192] to ensure that teachers are held accountable for any sexual abuse that they commit against their students.

B. *Female Genital Mutilation (FGM)*

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.[193] 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."[194]

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,[195] 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.[196] Without a robust enforcement mechanism and equitable implementation across the country, the Prohibition of Female Genital Mutilation Act will remain ineffective.

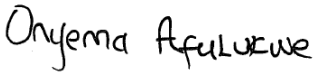
IV. Recommendations for the government of Kenya

We hope that the Committee will consider making the following recommendations to the Government of Kenya:

1. The government should scale up its efforts to reverse the alarming trend of increasing maternal mortality including by ensuring women and girls' access to quality and respectful antenatal, delivery and postnatal services. The government should take the necessary measures to effectively implement the Presidential Directive on Free Maternity Services including by allocating sufficient resources. It should also undertake measures aimed at preventing the detention, abuse and mistreatment of women in maternal health care facilities.
2. The government should clarify the laws on abortion including by reinstating the "Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya" and provide healthcare professionals with the necessary trainings and resources to provide abortion and post-abortion care without fear of prosecution, bias or discrimination.
3. The government should ensure that all women and girls have access to comprehensive family planning information and services, including by allocating adequate budget to address stock-outs of contraceptives and training health care professionals and raising awareness of the public to combat stigma against contraceptive use.
4. The government should take concrete steps to implement the 2015 Protection against Domestic Violence Act by establishing reporting mechanisms at police stations as well as allocating adequate budget for the provision of medical, psychosocial and legal support to victims of sexual and physical violence. It should also establish a system to gather data on the number of cases reported, investigated and successfully prosecuted to monitor the effectiveness of the strategies it's implementing to address violence against women and girls.

5. The government should intensify its efforts to combat FGM including through allocating adequate resources to the Anti-FGM board and implementing the law against FGM.

Sincerely,



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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) [hereinafter ICESCR].
[2] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), U.N. Doc. A/34/46 (1979) [hereinafter CEDAW]; International Covenant on Civil and Political Rights, U.N. Doc. A/6316 (1966) [hereinafter ICCPR]; African Charter on Human and Peoples' Rights, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) [hereinafter African Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, CAB/LEG/66.6 [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] *See* WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2015 ANNEX 19 (2015), *available at* http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf [hereinafter WHO, TRENDS IN MATERNAL MORTALITY].
[23] *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].
[24] *See* WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2013, *supra* note 22, at 33.
[25] CESCR Committee, *List of issues in relation to the combine second to fifth periodic reports of Kenya*, para. 27 U.N. Doc. E/c.12/KEN/Q/2-5 [hereinafter CESCR Committee, List of issues].
[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) [hereinafter Kenya Periodic 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* CESCR Committee: *List of issues in relation to the combine second to fifth periodic reports of Kenya: Replies of Kenya to the list of issues*, para. 118, U.N.Doc. E/C.12/KEN/Q/2-5/Add.1 (2016) [hereinafter *Replies of Kenya to the list of issues*].
[32] *See* KDHS 2014 SUMMARY, *supra* note 27, at 24, tbl.3.13 & 25, tbl.3.14.
[33] *Id.*
[34] *Id.*
[35] *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.
[36] *See* KDHS 2014 SUMMARY, *supra* note 27, at 27.
[37] *See id.*
[38] Kenya Periodic Report 2013, *supra* note 26, at para. 187.
[39] *Maternal Care Free, President Kenyatta Announces*, DAILY NATION, June 1, 2013, *available at* http://www.nation.co.ke/News/Govt-rolls-out-free-maternal-care/-/1056/1869284/-/gywvvrz/-/index.html.
[40] Beyond Zero: Inspiring Action. Changing Lives *available at* www.beyondzero.or.ke (last accessed December 14, 2015).
[41] *Id.*
[42] Beyond Zero Campaign Delivers the 22nd Mobile Clinic in Kakamega, April 9, 2015 *available at* http://www.ke.undp.org/content/kenya/en/home/presscenter/articles/2015/beyond-zero-campaign-delivers-the-22nd-mobile-clinic-in-kakamega.html.
[43] *See* CENTER FOR REPRODUCTIVE RIGHTS & FIDA KENYA, FAILURE TO DELIVER: VIOLATIONS ON WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [hereinafter FAILURE TO DELIVER].
[44] CESCR Committee, *Concluding Observations: Kenya*, para. 32, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[45] Focus group discussion participant, in Nairobi, Kenya (Mar. 1, 2012) (on file with the Center for Reproductive Rights).
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[50] Focus group discussion, *supra* note 45.
[51] FAILURE TO DELIVER, *supra* note 43, at 57.
[52] *Id.*
[53] *Id.*, at 52.
[54] 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.
[55] *Id.* at 53–54.
[56] *Id.* at 56.

[57] *Id.*, at 63.
[58] *Id.* at 72–73.
[59] 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].
[60] *Id.*, at 52.
[61] *See* FAILURE TO DELIVER, *supra* note 43, 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).
[62] FAILURE TO DELIVER, *supra* note 43, at 29, 33-35
[63] Awuor & Another v. A.G. of Kenya & 4 Others, Petition No. 562 of 2012, 7–9 (High Ct. Kenya, Nairobi).
[64] *Id.* at 21.
[65] *Id.* at 24.
[66] *Id.*
[67] *Id.* at 26.
[68] *See* Kenya Periodic Report 2013, *supra* note 26, at para. 182.
[69] *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).
[70] *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.
[71] 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.
[72] 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 70, at 6.
[73] Reuben Wanyama, *Kidero abolishes free maternity services in Nairobi County*, CITIZEN DIGITAL (Oct. 29, 2015), http://citizentv.co.ke/news/kidero-abolishes-free-maternity-services-in-nairobi-county-104439/.
[74] *Id.*
[75] 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.
[76] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 6 (High Ct. Kenya, Bungoma).
[77] Owino: *Not so Free*, *supra* note 75, at 1, 4.
[78] *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)].
[79] *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).
[80] *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 79.
[81] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 4 (High Ct. Kenya, Bungoma).
[82] CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[83] CEDAW Committee, *Concluding Observations, Kenya*, para. 38, U.N. Doc. CEDAW/C/Ken/CO/7 (2011).

[84] CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[85] CESCR Committee, List of issues, *supra* note 25, para. 28.
[86] 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 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].
[87] CONST. REPUBLIC OF KENYA, 2010, art. 26(1) (4).
[88] The Penal Code, (2009) Cap. 63 §§ 158-160 (Kenya).
[89] 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.
[90] 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].
[91] *Replies of Kenya to the list of issues*, *supra* note 31, para. 119.
[92] *See* Reproductive Health Care Bill (2014), *Supra note* 78, at §§ 20.
[93] *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) [hereinafter 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).
[94] Ministry of Public Health and Sanitation, Memo to health care providers on abortion training and Medabon (2014) (on file with the Center).
[95] *Id.*
[96] KNCHR REPORT 2012, *supra* note 59, at 47.
[97] *Id.* at 66–67.
[98] 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.
[99] *See id.*
[100] *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).
[101] GUTTMACHER FACT SHEET 2012, *supra* note 85.
[102] FAILURE TO DELIVER, *supra* note 43, at 24–25 (finding that half of the women treated by a hospital for complications from unsafe abortion were under the age of 20).
[103] 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.
[104] *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.
[105] *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).
[106] 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).
[107] Muchangi, *Alarm Over Unsafe Abortion*, *supra* note 93.
[108] *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*].
[109] *See id.* at 3.
[110] *See* KNCHR REPORT 2012, *supra* note 59, at 49–59; IN HARM'S WAY, *supra* note 104, at 76.
[111] 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.
[112] 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.
[113] *See* Ziraba, *Study of Abortion Complication* Severity, *supra* note 108, at 7.
[114] *See id.*
[115] GUTTMACHER IN BRIEF 2012, *supra* note 103, at 2. IN HARM'S WAY, *supra* note 104, at 88–90.
[116] FAILURE TO DELIVER, *supra* note 43, at 25; IN HARM'S WAY, *supra* note 104, at 92–93.
[117] IN HARM'S WAY, *supra* note 104, at 76–78 (noting further that fears of prosecution are not unfounded despite the legality of the treatment).
[118] FAILURE TO DELIVER, *supra* note 43, at 25.
[119] IN HARM'S WAY, *supra* note 104, at 90–92.
[120] CEDAW Committee, *Concluding Observations: Kenya*, para. 38(d), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[121] CESCR Committee, *Concluding Observations: Kenya*, para. 33, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[122] *Id*.
[123] *See* Kenya Periodic Report 2013, *supra* note 26, at 41.
[124] *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.*
[125] KDHS 2008–09, *supra* note 23, at 61 (reporting that 46% of women used modern contraceptives).
[126] *See* KDHS 2014 Summary, *supra* note 27, at 20.
[127] *See id.* at 20–21 & tbl.3.11.
[128] *See id.* at 20.
[129] *See id.* at 17–19.
[130] *See* CENTER FOR ECONOMIC AND SOCIAL RIGHTS, FACT SHEET 4: KENYA *available at* http://www.cesr.org/downloads/Kenya%20Fact%20Sheet.pdf.
[131] *See* KDHS 2014 Summary, *supra* note 27, at 18–19.
[132] *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).
[133] IN HARM'S WAY, *supra* note 104
, at 45.
[134] *Id.*, at 44–45.
[135] 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 132, 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).
[136] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 132, at 119.
[137] CESCR Committee, List of issues, *supra* note 25, para. 29.
[138] *Replies of Kenya to the list of issues*, *supra* note 31, para. 120-125.
[139] IN HARM'S WAY, *supra* note 104, at 46.
[140] *Id.*, at 46.
[141] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 132, at 126.
[142] IN HARM'S WAY, *supra* note 104, at 47.
[143] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 132, at 126; IN HARM'S WAY, *supra* note 104, at 47–48.
[144] WHO, *Emergency Contraception, Fact Sheet No. 244* (2012), http://www.who.int/mediacentre/factsheets/fs244/en/ (last visited July 6, 2015).
[145] NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE, 2014, *supra* note 90, at 14.

[146] 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*].
[147] 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.
[148] *Id.* at 1.
[149] 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.
[150] IN HARM'S WAY, *supra* note 104, at 47; *EC Status and Availability*, *supra* note 143.
[151] *Id.*, at 47.
[152] 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).
[153] IN HARM'S WAY, *supra* note 104, at 47–48.
[154] *Id.*, at 47.
[155] 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.
[156] IN HARM'S WAY, *supra* note 104, at 44.
[157] Maputo Protocol, *supra* note 2, art. 14(1) (b)-(c).
[158] *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).
[159] CESCR Committee, *Concluding Observations: Kenya*, para. 14, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[160] Kenya Periodic Report 2013, *supra* note 26, at para. 98.
[161] *Id.*, at para. 57 (describing the bills that were passed or introduced to address issues of sexual violence in Kenya).
[162] CESCR Committee, *Concluding Observations: Kenya*, para. 22, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[163] 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).
[164] *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).
[165] KDHS 2008–09, *Supra* note 23, at 253.
[166] *See* KDHS 2014 SUMMARY, *supra* note 27, at 59, tbl. 3.40.
[167] *Kenya: Uhuru Signs Domestic Violence Bill Into Law*, The Star, May 14, 2015 *available at* http://allafrica.com/stories/201505150096.html.
[168] *See* The Protection Against Domestic Violence Act, 2015, Kenya Gazette Supplement No. 60 (Acts No. 2) (2015) *available at* https://ke.boell.org/sites/default/files/uploads/2015/08/protectionagainstdomesticviolenceact_2015_1.pdf [hereinafter Protection Against Domestic Violence Act 2015]
[169] *Id.*
[170] CESCR Committee, List of issues, *supra* note 25, para. 20.
[171] *Replies of Kenya to the list of issues*, *supra* note 31, para. 92.
[172] *Id.*, para. 93.
[173] Heinrich Boll Stiftung East & Horn of Africa, The Protection Against Domestic Violence Act (PADV) 2015 (Aug. 27, 2015) *available at* https://ke.boell.org/2015/08/27/protection-against-domestic-violence-act-padv-2015 (last accessed Jan. 8, 2016).
[174] Protection Against Domestic Violence Act 2015, *supra* note 168, Art. 6 (4) (a) - (b).
[175] KNCHR REPORT 2012, *supra* note 59, at 82–83.
[176] *Id.* at 88.
[177] 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.

[178] *Id.* at 83.

[179] *See* IRC, MY ACTION COUNTS, *supra* note 177, at 37–41.

[180] *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) [hereinafter UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA).

[181] This information was not disaggregated into male and female statistics. *See* Migiro, *One third of Kenyan girls*, *supra* note 2172; *see also* UNICEF, HIDDEN IN PLAIN SIGHT: A STATISTICAL ANALYSIS OF VIOLENCE AGAINST CHILDREN 85 (2014), http://files.unicef.org/publications/files/Hidden_in_plain_sight_statistical_analysis_EN_3_Sept_2014.pdf.

[182] *Id*.

[183] S*ee* Migiro, *One third of Kenyan girls*, *supra* note 180.

[184] Professional help includes assistance provided by institutions such as the police department, medical facilities, legal aid, religious groups and/or social services. Female victims, especially adolescents, are far more likely to seek assistance from their families or close friends. UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 180, 129, tbl.7.2.1.

[185] *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).

[186] UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 180, at 51.

[187] 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/.

[188] *Id.* paras. 111–12, 123.

[189] *Id.* paras. 123, 132–33, 150.

[190] *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.

[191] W.J. & Another, (2015) eKLR, para. 164.

[192] *Id.*

[193] CESCR Committee, *Concluding Observations: Kenya*, para. 23, U.N. Doc. E/C. 12/KEN/CO/1 (2008).

[194] *See* CAT Committee, *Concluding Observations: Kenya*, para. 26, U.N. Doc. CAT/C/KEN/CO/2 (2013).

[195] Kenya Periodic Report 2013, *supra* note 26, at para. 101.

[196] *See* KDHS 2014 SUMMARY, *supra* note 27, at, 61, tbl.3.42.