CENTER FOR REPRODUCTIVE RIGHTS

Committee on the Elimination of Discrimination against Women
Human Rights Treaties Division
Office of the United Nations High Commission for Human Rights
Palais Wilson – 52, rue des Pâquis
CH-1201 Geneva, Switzerland

February 20, 2016

Re: Supplementary information on Kenya scheduled for review by the Committee on the Elimination of Discrimination against Women during the Pre-Sessional Working Group of the 68th Session

Distinguished Committee Members,

The Center for Reproductive Rights (the Center) hopes to further the work of the Committee by providing independent information on Kenya, scheduled to be reviewed during the pre-sessional working group of the 68th session. The letter addresses: the high rate of preventable maternal mortality and morbidity; detention, abuse and mistreatment of women seeking maternal health care services; inaccessibility of safe abortion services and post-abortion care; lack of access to comprehensive family planning services and information; and gender-based violence and female genital mutilation.

A. High Incidences of Preventable Maternal Mortality and Morbidity

Several treaty-monitoring bodies (TMBs), have framed the issue of maternal mortality as a violation of women's right to health and right to life.[1] In its 2007 Concluding Comments the Committee recommended that the **government of Kenya step up its efforts to reduce the incidence of maternal and infant mortality… and increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas**.[2] In its 2011 Concluding Observations on Kenya the

[1] *CEDAW Committee Concluding Observations*: *Belize*, para. 56 (1999), Committee on Economic Social and Cultural Rights (ESCR Committee), *Gen. Comment No. 14* para. 21; *see, e.g.*, 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.
[2] CEDAW Committee, *Concluding comments of the Committee on the Elimination of Discrimination against Women*, Kenya, para 38, U.N. Doc CEDAW/C/KEN/CO/6 (2007) [hereinafter *CEDAW Committee Concluding Comments Kenya (2007)*]

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

Committee expressed its concern about the increasing maternal mortality rate.[3] Addressing this recommendation in its most recent report to the Committee the government of Kenya highlights: the 2013 introduction of free maternity services in all public facilities, funding dedicated to the free maternal health-care programme, free access to health centres and dispensaries, recruitment of community nurses and health workers, and the Beyond Zero Campaign.[4]

Despite these efforts Kenya's maternal mortality rate (MMR) remains high. The World Health Organization's (WHO) 2015 report found that MMR had only decreased by 1.2% per year since 1990.[5] According to the same report, 510 Kenyan women and girls die per every 100,000 live births,[6] which is an increase from the MMR of 400 deaths per 100,000 live births documented in the 2013 version of the same WHO report.[7]

Part of this increasing trend can be attributed to the significant challenges low-income women, women with lower levels of education, and those in rural areas, encounter in accessing quality maternal health care services. According to the 2014 Kenya Demographic Health Survey summary report (2014 KDHS), only 58% of pregnant women attended the WHO recommended four or more antenatal care visits.[8] A woman's geographic location has a significant impact on her access to antenatal care: 68% of women living in urban areas are more likely to attend four or more antenatal care visits compared to 51% of those living in rural areas.[9] 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.[10]

Although free maternity services were introduced in 2013 through a Presidential Directive, implementation of the directive remains a challenge. 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.[11] 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.[12] 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.[13] Further, while the WHO recommends postnatal care

[3] CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women Kenya*, para. 37[3], U.N. Doc. CEDAW/C/Ken/CO/7 (2011). [hereinafter CEDAW Committee, *Concluding Observations*, Kenya (2011)]

[4] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Eighth periodic report of States parties due in 2015: Kenya*, para, 52, 53 U.N. Doc. CEDAW/C/KEN/8 (2016) [hereinafter Kenya Periodic Report 2016]

[5] 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]..

[6] *Id.*, 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].

[7] *See* WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, *supra* note 5, at 33.

[8] *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 February 6, 2017).

[9] *See* KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY: KEY INDICATORS 23 (2015) [hereinafter KDHS 2014 SUMMARY], at 23, *available at* https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf

[10] *Id.*

[11] *See* KDHS 2014 SUMMARY, *supra* note 9, at 24, tbl.3.13 & 25, tbl.3.14.

[12] *Id.*

[13] *Id.*

starting an hour after giving birth for the first 24 hours in order to check for complications,[14] only 51% of women receive a postnatal checkup within two days of giving birth.[15]

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.[16] The Campaign has delivered forty-seven mobile clinics since its inception.[17] 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.[18] 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

The Committee during its review of Kenya in 2011 recommended that the government, "strengthen its efforts to reduce the incidence of maternal mortality … and increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas."[19] However, a fact finding report conducted by the Center and FIDA- Kenya, revealed that women who attend maternal health care services are frequently neglected and encounter systematic abuse from health care professionals and staff.[20] , Violations include 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.[21] Most of the women were detained for durations of between two weeks and two months.[22] 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.[23] 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."[24] Most women who are detained are denied post-natal and other crucial medical care[25]

[14] *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?ua=1
[15] *See* KDHS 2014 SUMMARY, *supra* note 9, at 27.
[16] Beyond Zero: Inspiring Action. Changing Lives *available at* www.beyondzero.or.ke (last accessed December 14, 2015).
[17] Nairobi gets 47th mobile clinic as phase one of Beyond Zero campaign ends, September 9, 2016 *available at* http://www.the-star.co.ke/news/2016/09/09/nairobi-gets-47th-mobile-clinic-as-phase-one-of-beyond-zero-campaign_c1418043 (last visited February 3, 2017).
[18] *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.
[19] CEDAW Committee, *Concluding Observations,* Kenya (2011), para. 38 (b)
[20] *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].
[21] Focus group discussion participant, in Nairobi, Kenya (Mar. 1, 2012) (on file with the Center for Reproductive Rights).
[22] *Id.*
[23] *Id.*
[24] CAT Committee, *Concluding Observations: Kenya*, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).
[25] Focus group discussion, *supra* note 21.

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.[26] 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. The government is currently appealing this ruling. Despite appealing the judgement the government needs to prioritize ending the detentions and rights violations by ensuring 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,[27] 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."[28] 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,[29] and the government has failed to allocate sufficient additional resources to remedy this issue.[30] 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.[31]

Despite the directive women still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.[32] Other key components of maternal health services, including antenatal and postnatal care, are also not covered under the directive.[33] Further,

[26] Awuor & Another v. A.G. of Kenya & 4 Others, Petition No. 562 of 2012, 7–9 (High Ct. Kenya, Nairobi).
[27] Kenya Periodic Report 2016, *supra* note 4, para. 52
[28] *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 February 3, 2015).
[29] *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?ver=2013-11-10-000000-000
[30] 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.
[31] 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 29, at 6.
[32] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 6 (High Ct. Kenya, Bungoma) (on file with the Center for Reproductive Rights).
[33] 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* http://www.awcfs.org/dmdocuments/reject/Reject_087.pdf_online_issue_87.

the Reproductive Healthcare Bill that debated in the senate in 2016 provides for free antenatal care,[34] but does not 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.[35] 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.[36]

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

A 2013 study conducted by the Ministry of Health estimated that nearly 465,000 abortions occured in Kenya in 2012.[37] That same year, approximately 120,000 women sought care in health care facilities for unsafe abortion-related complications.[38] One study found that up to 60% of all gynecologic emergency hospital admissions are a result of complications from unsafe abortion.[39] In 2011 The Committee noted with concern that illegal abortion remains one of the leading causes of the high MMR and that Kenya's restrictive abortion law further leads women to seek unsafe and illegal abortion.[40] The Committee urged the state to "[p]rovide women with access to good-quality services for the management of complications arising from unsafe abortions and to consider reviewing the law relating to abortion with a view to removing punitive provisions imposed on women who undergo abortion."[41] 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.[42]

In its current report to the Committee the government of Kenya states that by specifying conditions under which abortion may be legally provided, the Constitution addresses the toll caused by unsafe illegal abortion.[43] However, the laws governing abortion in Kenya remain confusing and contradictory. While Kenya's 2010 Constitution provides for abortion in situations where a woman's life or health is at risk,[44]

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[34] *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

[35] *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 (last visited February 6, 2017); 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 February 6, 2017).

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

[37] MINISTRY OF HEALTH., KEY FINDINGS OF A NATIONAL STUDY: INCIDENCE AND COMPLICATIONS OF UNSAFE ABORTION IN KENYA 7 (2013), *available at* https://www.guttmacher.org/pubs/FB-abortion-in-Kenya-2013.pdf

[38] *See id.*

[39] *See* 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); *See also* GUTTMACHER INSTITUTE, IN BRIEF: ABORTION AND UNINTENDED PREGNANCY IN KENYA 3 (2012) [hereinafter GUTTMACHER IN BRIEF 2012], *available at* https://www.guttmacher.org/sites/default/files/report_pdf/ib_unsafeabortionkenya.pdf

[40] CEDAW Committee, *Concluding Observations*: *Kenya*, para 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).

[41] *Id.*, at para. 38,

[42] CAT Committee, *Concluding Observations: Kenya*, para. 28, U.N. Doc. CAT/C/KEN/CO/2 (2013).

[43] Kenya Periodic Report 2016, *supra* note 4, para. 158.

[44] CONST. REPUBLIC OF KENYA, 2010, art. 26(1) (4).

the Penal Code has not been revised to reflect this change.[45] Therefore, a woman could still face prosecution for seeking an abortion in circumstances allowed under the Constitution. 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.[46] 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."[47] 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.

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.[48] 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.[49] 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.[50] 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. The harshness of Kenya's abortion laws most heavily impacts young women[51]—for whom the unintended pregnancy rate is highest[52]—even where relatively safe abortion procedures are available, because the cost of these services often exceeds these women's financial resources.[53]

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 is currently pending awaiting the constituting of a bench of three judges.

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[45] The Penal Code, (2009) Cap. 63 §§ 158-160 (Kenya).

[46] MINISTRY OF PUBLIC HEALTH & SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 13 (2d ed., 2009), *available at* http://www.svri.org/nationalguidelines.pdf.

[47] 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].

[48] *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 February 20, 2017) [hereinafter Muchangi, *Alarm Over Unsafe Abortion*]; Joyce Chimbi, *Kenya: A Society at Crossroads Over Devastating Impact of Unsafe Abortions*, THE STAR (Feb. 16, 2017), *available*. http://aphrc.org/archives/4099

[49] Ministry of Public Health and Sanitation, Memo to health care providers on abortion training and Medabon (2014) (on file with the Center).

[50] *Id.*

[51] FAILURE TO DELIVER, *supra* note 20, at 24–25 (finding that half of the women treated by a hospital for complications from unsafe abortion were under the age of 20).

[52] 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.

[53] *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.

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.[54] Moreover, a 2015 study found that 77% of Kenyan women seeking PAC suffered from moderate or severe complications.[55] However, barriers to access to PAC create delays in receiving essential treatment, which cause disproportionately higher rates of severe post-abortion complications.[56]

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.[57] Although the government has stated that PAC "is legal and not punishable by any part of Kenya laws,"[58] this declaration only offers protection to the health care providers and not to women who seek PAC.[59] 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."[60] These delays can have fatal consequences for women that present with treatable conditions.[61]. 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.[62]

C. Lack of Access to Family Planning Information and Services

In its 2011 Concluding Observations, the Committee urged Kenya to "[s]trengthen and expand efforts to increase knowledge of and access to affordable contraceptive methods throughout the country and ensure that women in rural areas do not face barriers to accessing family planning information and services."[63] However, according to the 2014 KDHS, only about half of Kenyan women (53.4%) are able to access modern methods of contraceptives,[64] an increase of only seven percentage points from the 2008 rate.[65] 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

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[54] Muchangi, *Alarm Over Unsafe Abortion*, *supra* note 48.
[55] *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 6-7 (2015), *available at* http://www.biomedcentral.com/content/pdf/s12884-015-0459-6.pdf [Ziraba, *Study of Abortion Complication Severity*].
[56] *See Id.*, at 1.
[57] 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), at 49–59 *available at* http://www.knchr.org/portals/0/reports/reproductive_health_report.pdf [hereinafter KNCHR Report 2012]; IN HARM'S WAY, *supra* note 53, at 76.
[58] 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.
[59] 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.
[60] *See* Ziraba, *Study of Abortion Complication* Severity, *supra* note 55, at 7.
[61] *See Id.*
[62] GUTTMACHER IN BRIEF 2012, *supra* note 109, at 2; *See also* IN HARM'S WAY, *supra* note 53, at 88–90.
[63] CEDAW Committee, *Concluding Observations: Kenya*, para. 38(d), U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[64] *See* KDHS 2014 Summary, *supra* note 99, 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.*
[65] KDHS 2008–09, *supra* note 25, at 61 (reporting that 46% of women used modern contraceptives).

currently using a contraceptive method.[66] The 2014 KDHS found that although women from all demographic backgrounds have significant unmet family planning needs,[67] 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.[68] In addition, usage disparities are even more pronounced by geographic area[69] 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—[70]use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.[71]

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.[72] 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.[73] Moreover, a woman's preferred method of contraception is often unavailable[74] or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members.[75] 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.[76]

In its latest report the government acknowledges that HIV/AIDS still poses one of the greatest challenges in Kenya and further that HIV prevalence is highest among women.[77] In its 2011 Concluding Observations the Committee urged the government to "[w]idely promote education on sexual and reproductive health and rights targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of STIs, including HIV/AIDS".[78] However the government has not provided information about the steps it is taking to increase adolescents' access to reproductive health information. Research shows that social stigma against the use of contraception is particularly problematic for adolescents, who are one of the groups most vulnerable to experiencing discrimination in access to family planning services. Young people in Kenya also lack formal and comprehensive sex

[66] *See* KDHS 2014 Summary, *supra* note 6, at 20.
[67] *See Id.* at 20–21 & tbl.3.11.
[68] *See Id.* at 20.
[69] *See Id.* at 17–19.
[70] *See* CENTER FOR ECONOMIC AND SOCIAL RIGHTS, FACT SHEET 4: KENYA *available at* http://www.cesr.org/downloads/Kenya%20Fact%20Sheet.pdf.
[71] *See* KDHS 2014 Summary, *supra* note 9, at 18–19.
[72] *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).
[73] IN HARM'S WAY, *supra* note 53, at 45.
[74] *Id.*, at 44–45.
[75] 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* note138, 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).
[76] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 72, at 119.
[77] Kenya Periodic Report 2016, *supra* note 4, para. 156.
[78] CEDAW Committee, *Concluding Observations, Kenya*, para. 39 (c) U.N. Doc. CEDAW/C/Ken/CO/7 (2011).

education,[79] resulting in misinformation about their reproductive health, including concerns about poor outcomes from using contraceptives.[80] These misconceptions lead to lower contraceptive use rates and a higher incidence of unplanned and unwanted pregnancies.[81]

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.[82] Indeed, the National Guidelines on the Management of Sexual Violence in Kenya requires that EC be available 24 hours a day for survivors of sexual violence in all health facilities, free of charge.[83] In Kenya, ten products of EC are registered,[84] and the Ministry of Health broadly recommends its use for those "who have had unprotected sexual intercourse and desire to prevent pregnancy."[85] The Ministry also has recognized that EC "is an important component of adolescent reproductive health."[86] 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.[87]

While the government states in its report that it provides Post Exposure Prophylaxis and Emergency contraception to victims of sexual violence who report to health facilities,[88] 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.[89] Some pharmacists also decline to distribute EC altogether or refuse to dispense it without a prescription,[90] although EC is registered in Kenya as an over-the-counter medicine.[91] 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.[92] Moreover, adolescents are routinely denied access to EC for arbitrary or discriminatory reasons such as "the person looks young."[93] A 2014 study found out that only 18% of

[79] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 72, at 126.
[80] IN HARM'S WAY, *supra* note 53, at 48-49.
[81] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 72, at 126; IN HARM'S WAY, *supra* note 53, at 49.
[82] WHO, *Emergency Contraception, Fact Sheet No. 244* (2012), http://www.who.int/mediacentre/factsheets/fs244/en/ (last visited July 6, 2015).
[83] NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE, 2014, *supra* note 47, at 14.
[84] International Consortium for Emergency Contraception, *EC Status and Availability: Kenya* (2016), http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/kenya/ (last visited, February 15, 2017) [hereinafter *EC Status and Availability*].
[85] 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.
[86] *Id.* at 1.
[87] 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.
[88] Kenya Periodic Report 2016,*supra* note 4, para. 75.
[89] IN HARM'S WAY, *supra* note 53, at 44-47; *EC Status and Availability*, *supra* note 143.
[90] IN HARM'S WAY, *supra* note 53, at 47.
[91] 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).
[92] IN HARM'S WAY, *supra* note 53, at 47–48.
[93] *Id.*, at 47.

women and girls surveyed in Nairobi have ever used EC.[94] 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.[95] 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.[96]

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

Gender-based violence has been addressed in many of the Concluding Observations on Kenya issued by various TMBs.[97] The Kenyan government noted in its report that it has passed and introduced various initiatives to address issues of gender-based violence, including the National Policy on Prevention and Response to Gender Based Violence, Protection against Domestic Violence, and Gender Based Violence Recovery centres in the largest public hospitals.[98] However, the government also acknowledges that a number of initiatives remain pending including the National Policy framework and guidelines for the administration of sexual violence and the National Guidelines on Rape and Sexual Violence Management.[99] The government further acknowledges, "Weak medico-legal linkages: medical (such as care and treatment) and legal (such as a survivor's access to justice) responses to GBV in order to guarantee survivor safety, effective prosecution of cases and uphold perpetrator rights to a fair trial. Kenya currently lacks a harmonized chain of custody of evidence across the medical, police and legal levels that ensures the plausibility of cases in court."[100] As a result, significant gaps remain in the legal and policy framework to address violence against women and girls; the government must do more to effectively implement the existing legal protections and ensure access to services for survivors of gender-based violence.

Sexual and Domestic Violence against Women and Girls

Despite chronic underreporting, data from various sources demonstrate that violence against women, sexual and otherwise, remains prevalent in Kenya. The 2014 KDHS shows that approximately 44% of ever-married women have experienced sexual or physical violence by their husband or partner, [101] which is not a significant decrease from 2008-2009 KDHS where 47% of ever-married women reported to having experienced such violence.[102] In addition, roughly 28% women aged 20-29 had experienced some form of violence in the previous 12 months preceding the survey.[103]

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[94] 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.

[95] IN HARM'S WAY, *supra* note 53, at 44.

[96] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14(1) (b)-(c), CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) [hereinafter Maputo Protocol]

[97] *See, e.g.*, CEDAW Committee, *Concluding Observations: Kenya*, paras. 17–24, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Human Rights Committee, *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/C/KEN/CO/3 (2012); Human Rights Council, *Universal Periodic Review: Kenya*, para. 101.48-53, U.N. Doc. A/HRC/15/8 (2010).

[98] Kenya Periodic Report 2016, *supra* note 4, paras. 63, 65, 74.

[99] *Id*., at para. 66

[100] *Id*., at para. 87 (describing the bills that were passed or introduced to address issues of sexual violence in Kenya).

[101] *See* KDHS 2014 SUMMARY, *supra* note 9, at 291,).

[102] KDHS 2008–09, *supra* note 6, at 253.

[103] *See* KDHS 2014 SUMMARY, *supra* note 9, at 308, tbl. 16.9.1.

In May 2015, the President signed into law the Protection against Domestic Violence Act[104] 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.[105] It also sets out protection mechanisms for victims, such as counseling and medical assistance, as well as protection orders against the perpetrator.[106] However, 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.[107] 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.[108]

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.

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.[109] 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.[110] Of those who had experienced violence, six out of ten have been physically abused.[111] Rape is rarely reported as a result of pervasive social stigma and a deep mistrust in police and the criminal justice system.[112] A 2012 UNICEF study determined that only 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.[113] 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

[104] *Kenya: Uhuru Signs Domestic Violence Bill Into Law*, The Star, May 14, 2015 *available at* http://allafrica.com/stories/201505150096.html

[105] *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]

[106] *Id*.

[107] 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).

[108] Protection Against Domestic Violence Act 2015, *supra* note 174, Art. 6 (4) (a) - (b).

[109] *See* Katy Migiro, *One Third of Kenyan Girls Subjected to Sexual Violence - Survey*, REUTERS (Nov. 28, 2012), http://news.trust.org//item/20121128172500-gedar survey (last visited February 17, 2017) [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).

[110] 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.

[111] *Id*.

[112] S*ee* Migiro, *One third of Kenyan girls*, *supra* note 110.

[113] 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 110, 129, tbl.7.2.1.

took place in school.[114] 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.[115]

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.[116] 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.[117] Although the TSC circular, or employee guidelines, mentions disciplinary action for the sexual assault of students,[118] the circular fails to indicate clear mechanisms for disciplinary action or provide sexual assault survivors with psychological or essential health care.[119] 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."[120] The Government must also follow the Court's order to "put in place an effective mechanism"[121] to ensure that teachers are held accountable for any sexual abuse that they commit against their students.

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

Maternal Health

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

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

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

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[114] *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 February 17, 2017).
[115] UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 110, at 51.
[116] 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/.
[117] *Id.* paras. 111–12, 123.
[118] *Id.* paras. 123, 132–33, 150
[119] *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.
[120] W.J. & Another, (2015) eKLR, para. 164.
[121] *Id.*

Unsafe Abortion and Lack of Access to Post-Abortion Care

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

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

Access to Family Planning Information and Services

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

Physical and Sexual Violence against Women and Girls

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

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