June 28, 2012

Human Rights Committee
Office of the United Nations High Commissioner for Human Rights

Re: Supplementary Information on Kenya, Scheduled for Review by the UN Human Rights Committee During its 105th Session

Honorable Committee Members:

This letter is intended to supplement the 3rd periodic report of the Government of Kenya, scheduled for review by the Human Rights Committee (the Committee) during its 105th session. The Center for Reproductive Rights (the Center) with headquarters in New York and a regional office in Kenya is an independent non-governmental organization that uses the law to advance reproductive freedom as a fundamental human right. The Center hopes to further the Committee's work by providing independent information concerning the rights protected in the International Covenant on Civil and Political Rights (the Covenant). This letter highlights several areas of concern related to the status of the reproductive health and rights of women and adolescent girls in Kenya.

Reproductive rights are fundamental to women's rights to life, equality and non-discrimination, and freedom from torture, cruel, inhuman and degrading treatment, and impact the exercise of additional human rights guaranteed by the Covenant. The commitment of states to respect, protect and fulfill these rights should receive serious attention. Further, women's reproductive health and rights receive broad protection under the Covenant.

We wish to bring to the Committee's attention the following areas of particular concern: high incidence of maternal mortality and morbidity; shortcomings in the delivery of reproductive health services; and, violence and discrimination against women.

I. The Right to Reproductive Health Care, including Maternal Health Care, Family Planning and Safe and Legal Abortion Services (Articles 3, 6, 7, 9, 17, 23, and 26)

The Covenant's guarantee of the right to life in Article 6 requires governments to take "positive measures" aimed at preserving life.[1] Such measures should respond to the needs of both women and men, in keeping with Articles 3 and 26, which guarantee equal enjoyment of the rights in the Covenant and equality before the law.[2] Because reproductive health care is essential to women's survival, these

provisions collectively give rise to a governmental duty to ensure the full range of reproductive health services, including the means of preventing unwanted pregnancy and safe abortion.

Under General Comment 28, states should also take measures to eliminate laws and public or private actions that interfere with the equal enjoyment by women of the rights under Article 17, and to protect women from any such interference.[3] The Committee has also recommended implementing legal and policy measures to ensure access to a full range of reproductive health care services and information, including safe contraceptives, family planning counselling, sexuality education and safe abortion services.[4] The Committee has recognized that lack of availability of family planning services and information compromises women's ability to participate equally in all aspects of social, economic and public life; and increases the incidences of unwanted pregnancies, unsafe abortions and maternal mortality.[5] In addition, the Committee has noted that young, poor, rural and minority women often face additional obstacles to reproductive health care, and has recommended that states take extra measures to ensure their access to health.[6]

The Committee has recognized that women's lack of access to contraceptives, including their high cost, is discriminatory.[7] The Committee has further called upon states to take measures "to ensure that women do not risk their life because of the existence of restrictive legal provisions on abortion," which force women to seek abortions under clandestine, unsafe conditions.[8] In this regard, the Committee has recommended liberalization of laws that criminalize abortion.[9]

A. HIGH INCIDENCE OF MATERNAL MORTALITY AND MORBIDITY

The Committee has identified women's lack of access to reproductive health services, including emergency obstetric care, as contributing to maternal mortality[10] and as a violation of their rights to equality[11] and life.[12] Reduction of maternal mortality is also a Millennium Development Goal agreed to by Kenya.[13] Kenya's commitment requires reducing the maternal mortality rate to 175 per 100,000 live births or less by 2015.[14] Yet, according to the 2008-2009 Kenya Demographic and Health Survey [2008-2009 KDHS], the maternal mortality ratio was 488 maternal deaths per 100,000 live births for the ten-year period prior to the survey,[15] and about 15% of deaths among women of reproductive age—15 to 49 years—are maternal deaths.[16] A May 2012 World Health Organization report identifies Kenya as one of the countries that have made "insufficient progress" towards improving maternal health and meeting MDG 5.[17] Further, these numbers do not capture the many instances of maternal morbidity where women survive pregnancy but suffer lasting pregnancy-related health problems and disabilities such as obstetric fistula.

The 2008-2009 KDHS, and a fact-finding report by the Federation of Women Lawyers Kenya (FIDA Kenya) and the Center reveal an alarming degree of rights violations occurring in medical facilities.[18] The fact-finding report documents how women are subjected to substandard medical services and negligent and abusive treatment at the hands of health care providers.[19] Women recount rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[20] The Kenya National Commission on Human Rights, in the just-released results of its public inquiry on violations of reproductive health and rights found that women were still receiving poor-quality maternal health services,[21] and were susceptible to abuse, preventable injuries, and death.[22] It further found that women, particularly in rural areas, routinely risked death due to inadequate

access to emergency obstetric care and post-natal care, and unsafe abortions.[23] Although in its official report to the Committee, the government acknowledges the country's high mortality rates and declining life expectancy, it makes no mention of the impact of maternal mortality.[24]

B. Abuse and Detention of Women in Health Care Facilities

The Covenant guarantees freedom from torture, inhuman or degrading treatment or punishment, the right to liberty and security of person,[25] and the right to privacy.[26] The Committee has stated in General Comment 20 that the prohibition of torture, inhuman or degrading treatment or punishment "relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim"[27] and applies to patients in medical institutions, among others.[28]

Women seeking maternal health care services in Kenya encounter discrimination based on grounds such as income, age, gender, and HIV status. Many women do not seek medical care because of the cost, while other women are denied entrance to health facilities because they are unable to afford the requisite deposit.[29] Patients who cannot pay the entire cost of medical care upfront may be denied full services even if they are admitted to a facility. They may also be subjected to verbal and physical abuse--one woman was told by a hospital staff member to continue suffering because she was responsible for her pregnancy. During the night, when her pain became so intense that she was forced to crawl to the nurses for assistance, they mocked her and asked if she was exercising.

Numerous women also abuse occurring around the suturing that is often necessary after childbirth. They described having to endure long, uncomfortable waits on a hard, wooden bench; unreasonably painful and poorly performed stitching; refusal to provide anesthesia; and verbal abuse from providers before, during, and after the process. This ill treatment was exhibited by providers across the spectrum; including doctors, midwives, nurses, and other staff in both public and private facilities—although the problems seem particularly prevalent in government hospitals, especially at Pumwani Maternity Hospital in Nairobi.

Interviews with health care users and providers also document that both public and private health facilities have an ongoing and longstanding practice of detaining patients who are unable to pay their medical bills.[30] Private facilities use detention to pressure patients' relatives to pay the bills, while public facilities use detention for this purpose, and also to determine whether a patient is poor enough to qualify for a waiver of fees. While detained, women who have only recently given birth may be forced to sleep on the floor or share a bed with others, deprived of sufficient food, and suffer verbal abuse from staff over their failure to pay. [31] For women whose babies have died, there is a particular psychological cruelty to being detained in a maternity ward, surrounded by other mothers and their infants.

In a March 2012 focus group discussion, organized by the Kenya Network of Grassroots Associations and the Center, formerly detained women recounted their experiences, including not being assisted by hospital staff until they paid a deposit. M.A., a mother of five children who was admitted at Pumwani Maternity Hospital on September 20th 2010, stated that "The hospital staff insisted that I had to pay a deposit before being admitted, I gave birth about 15 minutes later and I am horrified to imagine what would have happened if I did not have the deposit demanded."[32] Although M. A. was technically "discharged" immediately, she was not able to pay the remainder of her bill and was detained in the hospital for three weeks and five days. She describes her period of detention as the lowest point of her life. "I was verbally

abused by the nurses. I had to sleep on the floor whenever the hospital admitted more patients. I never got a change of hospital gown and beddings. And my children who were all alone in the house had to cater for themselves."[33]

A similar experience was recounted by M.O. who had a caesarean section at the same hospital in November 2010. She was detained for almost two weeks till her relatives paid. "At some point during the detention I was forced to sleep on the floor despite undergoing another surgery to correct a ruptured bladder. I failed to get meals on many occasions especially when patients were many in the wards. Nurses would not clean my wound and I had to rely on my relatives who visited me to clean up the wound."[34] M.W., who gave birth at Kenyatta National Hospital and was detained for one and half months, described how the social workers are always unavailable and the nurses would abuse her saying, "Why were you getting pregnant? Look for money to pay your bill. We are not running a charity here."[35]

The KNCHR's inquiry into abuses and violations of women's rights in health care facilities released in May 2012 confirmed the ongoing existence of detentions and other violations and urged the government to address them.[36]

C. VIOLATIONS OF THE RIGHTS OF WOMEN LIVING WITH HIV

In its 2005 concluding observations on Kenya, the Committee expressed concern at the unequal access to treatment experienced by people living with HIV, and asked the government to take steps to ensure equal access to treatment.[37] However, women in Kenya still experience inadequate HIV-treatment counseling and access to treatment due to factors such as lack of adequately trained staff,[38] and inappropriate or unaffordable fees.[39] Women interviewed by FIDA Kenya/the Center stated that they did not receive adequate counseling about HIV-treatment decisions.[40]

While women in general often experience abuses and harassment in seeking delivery services in Kenyan health facilities,[41] this abuse can be exacerbated for women who are HIV positive. Women living with HIV/AIDS often confront biases and negative attitudes from health care providers, particularly regarding their sexual and reproductive health practices, although discrimination against persons living with HIV is prohibited by law.[42] Interviewees described instances of discrimination when seeking antenatal and delivery services. These women were frequently turned away from public-health facilities or placed in secluded areas of the hospital.[43] They were reprimanded for bearing children or being sexually active, and denied access to contraception and maternity services.[44]

Pregnant women in Kenya may access testing to determine their HIV sero-status at antenatal clinics in conjunction with other antenatal services. While the Kenyan Government has produced a number of key documents outlining how testing and counseling should be provided in these contexts and in general, and which contain a range of rights protections, these protections are not always realized in practice. Interviews verified that testing for HIV without the informed consent of the patient is a frequent occurrence.[45] FIDA Kenya/the Center interviewed women who sought treatment at public hospitals and only discovered that they had received an HIV test when they overheard a health care professional discussing their sero-status with others.[46] These violations of confidentiality and lack of proper disclosure compromise the autonomy and privacy of women. The May 2012 results of the KNCHR's inquiry confirmed that testing without consent, abuses, and other problems are ongoing, and concluded that

“[p]eople living with HIV and A[IDS], especially women, experience myriad forms of sexual and reproductive rights violations.[47]

In addition to violations of informed consent and confidentiality, women described receiving inadequate counseling and stated that health workers were often unwilling to respond to their questions about ways they could avoid transmitting HIV to their children. The significance of this violation cannot be over-stated considering that “[t]he major cause of HIV/AIDS among children is transmission of HIV during pregnancy, delivery, and breast-feeding.”[48] In the absence of any intervention, children who are born to women living with HIV have a 5-10% risk of acquiring HIV during pregnancy, a 10-20% risk of acquiring HIV during labor or delivery, and a 5-20% risk of acquiring HIV while breastfeeding.[49] Treating a pregnant women living with HIV with antiretroviral medication during pregnancy and labor, as well as treating the child after birth, can decrease the risk of HIV contraction to 2%.[50]

D. LACK OF ACCESS TO COMPREHENSIVE FAMILY PLANNING SERVICES AND INFORMATION

Access to family planning services and information is central to protecting women’s and girls’ rights to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate health care, or they may seek out unsafe illegal abortions that can result in complications or death. A 2009 Guttmacher Institute report notes that overall, more than 40% of births in Kenya are unplanned.[51] The report also indicates that 25% of married women were found to have an unmet need for family planning, a statistic which has barely changed over the course of a decade.[52] The 2008-2009 KDHS further reveals 17% of births are unwanted and 26% are mistimed.[53]

The government’s submission to the Committee states that “only 39 per cent of married women and 46 per cent of sexually active unmarried women use any method of family planning, thus exposing themselves to unwanted pregnancies and various sexually transmitted infections.”[54] Contraceptive access is impeded by a number of factors including the government’s failure to ensure an adequate and consistent supply of contraceptives, financial barriers, and discriminatory service provision caused by the stigma that surrounds women’s and girls’ sexuality in Kenya.[55]

Kenya’s public health facilities have experienced consistent shortages or “stock-outs” of contraceptives, caused in part by the government’s inadequate budgetary allocations and delays in releasing allocated funds from the treasury.[56] While private facilities are less likely to experience contraceptive stock-outs, most Kenyans cannot afford their prices.[57]

Although the Ministry of Health’s policy requires that contraceptives at government facilities and government-supplied contraceptives at private facilities must be free of charge, the latest government survey on the issue, the 2010 KSPAS, found that about 70% of government facilities charged user fees for family planning services and 32% of facilities charged for the contraceptive method itself.[58] Other obstacles include incorrect and biased family planning information and absence of supplies necessary to insert certain methods.[59] Adolescents face additional barriers such as stigma and discrimination while trying to access contraceptives and providers acknowledge the absence of youth-friendly family planning services.[60]

Access to emergency contraception (EC) in Kenya is also limited by insufficient supplies and negative provider attitudes.[61] Despite the clear public demand for EC, Kenyan public health facilities are insufficiently stocked.[62] A Population Council study found that pharmacists sometimes demand a doctor's prescription before dispensing the medication, even though EC is an over-the-counter drug and not subject to such a restriction.[63] There are also misperceptions about the appropriate uses for EC. For instance, some health care providers believe that EC should only be available to rape victims, despite the fact that the 2008 Ministry of Health Guidelines on EC clearly states that it is intended to be used after unprotected sex and can safely be used by adolescents.[64] As a result, women report being arbitrarily denied EC based on marital status, age, and health care providers' personal perceptions of what constitutes "abuse" of EC.[65]

E. Unsafe Abortion

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. Where death does not result from unsafe abortion, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, or infertility. Unsafe abortion is the cause of 35% of Kenya's maternal deaths.[66] The Committee has specifically expressed concern over the criminalization of abortion in Kenya, including in cases of rape and incest, and its link to maternal mortality.[67] In its 2005 Concluding Observations, the Committee expressed concern at the high maternal mortality rate in Kenya most of which was due to the prevalence of unsafe abortions, and urged the government to improve access to family planning services, and ensure that its abortion laws comply with the ICCPR.[68]

With the promulgation of Kenya's new constitution in August 2010 the legal framework on abortion has improved: under the right to life abortion is now permitted if, "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the [pregnant woman] is in danger . . . ."[69] (Prior to this reform, Kenya's law on abortion was one of the most restrictive in the world, allowing abortion only to save the life of the pregnant woman.) However, the current Kenyan law still does not provide an explicit exception in cases of rape and incest, in spite of the high rates of sexual violence, discussed in detail below, and limited access to contraception.[70] This omission directly contradicts the Committee's General Comment 28, which emphasizes the need for access to safe abortion for women who have become pregnant as a result of rape. [71]

Without widespread education on the new constitution's provisions, the challenges associated with a lack of clarity surrounding Kenya's abortion laws and policies will remain. This is evident in the results of the KNCHR's inquiry which found that lack of access to safe and legal abortion was forcing women to use crude and unsafe methods often running the risk of permanent injuries or death or of being arrested.[72]

In its public inquiry report, the KNCHR recognized that unsafe and illegal abortions contribute to the country's high levels of maternal mortality and issued several recommendations to the government.[73] Some of the recommendations include that the government guarantee availability of safe abortion services in all health facilities, that abortion services are affordable, train police officers to eliminate the arrest and harassment of both the health care providers who offer safe and legal abortion services and the women who receive the services.[74] It is not yet clear whether the government will take immediate steps to implement these recommendations.

II. VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS (ARTICLES 3, 6, 7, 9, 17 & 24)

As previously noted, Article 7 of the Covenant states that no one shall be subjected to torture, inhuman or degrading treatment, or punishment, and Article 6 ensures the individual's right to life. These two rights are non-derogable.[75] Further, Article 3 provides for the equal enjoyment by both sexes of the Covenant's rights; Article 9 guarantees the right to liberty and security of person,[76] and Article 17 (1) protects the right to privacy.[77] These rights are violated when women have no protection from sexual violence, including in schools, and where governments fail to enact and enforce laws protecting women's physical safety and integrity.[78] The Committee has urged states to promulgate laws providing effective protection against rape, sexual abuse, and violence against women.[79] Further, the Covenant grants special protection to children under Article 24[80] which is interpreted to include the right of children to live free from violence, particularly rape.[81] The Committee has noted that to ensure these rights, states must provide effective protection through mechanisms that thoroughly investigate violations and provide appropriate remedies, whether these violations were inflicted by persons acting in an official or private capacity.[82]

A. SEXUAL VIOLENCE INCLUDING IN SCHOOLS

While sexual violence is widely under-reported, making it difficult to gather fully comprehensive statistics on its prevalence, figures indicate that it is a serious blight on the lives of Kenyan women. In its 2005concluding observations, the Committee expressed concern at the prevalence of violence against women in Kenya and noted that women were not given adequate legal protection from sexual violence.[83] It urged the government to adopt effective and concrete measures to address such violence, prosecute perpetrators, and assist victims of sexual violence as required.[84]

In 2009, a non-governmental organization, Men for Gender Equality Now, compiled data on rape from various sources, including police records, and found that about 16,400 rape cases are reported every year.[85] It also found that police reports show that "sexual assault cases constitute 50 per cent of offences reported to the force."[86] Sexual violence also occurs in marital and intimate partner relationships. A 2008 United States Agency for International Development (USAID) study determined that Kenya has one of the highest rates of sexual violence between intimate partners of the ten countries surveyed, at 15%.[87] The data also exposed a significant link between intimate partner violence and unintended pregnancies.[88]

As of 2012, the KNCHR public inquiry report confirmed that sexual violence remains high.[89] Although the 2006 Sexual Offences Act is an improvement over earlier piecemeal and inadequate laws on sexual violence, there are serious shortcomings in the legislation such as the exclusion of marital rape as a punishable offence. Furthermore, the act provides that any person who falsely alleges a sexual offence against another person is guilty of an offence and is liable to punishment equal to that for the offence complained of.[90] This provision could discourage reporting of cases of sexual violence for fear of being punished if the case fails—for instance if poor police investigation results in an acquittal.

In addition, while the National Guidelines for the Medical Management of Rape/Sexual Violence outline the importance of providing counseling, emergency contraception, and post-exposure prophylaxis for victims of sexual violence as well as the importance of properly gathering evidence that can be used in prosecution,[91] the guidelines are not widely disseminated or known.[92] Many women who survive violence never receive EC and it is often not offered to sexual violence survivors who seek treatment at

faith-based facilities.[93]

Sexual violence is also prevalent in schools throughout Kenya but very little is being done to address the problem. In addition to the immense emotional and psychological impact, girls who have been raped face the possibility of becoming pregnant or acquiring an STI. Pregnant adolescents are often forced out of school and into early marriages or turn to illegal, unsafe abortions. Sexual abuse by a teacher or school official can also lead a survivor to be reluctant to return to school or to excel in classes out of fear of being noticed by her abuser.[94] These crimes often go unreported because the victim fears social stigma, negative repercussions at school, or further abuse at the hands of the investigating agency.[95]

One study suggests that nearly 60% of school-aged children have faced sexual harassment.[96] A Center for the Study of Adolescence study reported that at least one in twenty high school boys coerced girls into sex.[97] Sexual abuse is also perpetrated against female students by their teachers.[98] A 2009 report by the Teachers Service Commission (TSC) and the Centre for Rights Education and Awareness estimated that 12,660 Kenyan schoolgirls were sexually abused by their teachers between 2003 and 2007.[99] They further note that this is likely a gross underestimation of the prevalence of abuse since 90% of cases of abuse do not even reach the TSC.[100]

The failure to address and rectify these violations of rights has been characterized as a form of "[v]iolence by [o]mission," which increases the victim's vulnerability to violence.[101] While the abuses often rise to the level of criminal conduct, the repercussion felt by the offending teacher is usually administrative, such as interdiction or suspension[102] or a transfer.[103] Inadequate administrative follow-up often results in the offending teacher's reinstatement leading to continued abuse of schoolchildren, while poor investigations and prosecutions lead to a less than 10% conviction rate of cases which go to court.[104] In April 2010, the TSC issued a Circular on Sexual Abuse expressing concern over "increasing cases of violence (physical, psychological and sexual) against pupils/students and recogniz[ing] that it is a violation of their human rights wherever it occurs."[105] However, the Circular does not specify what penalties beyond "disciplinary action" will be incurred.[106]

B. Discrimination Against Pregnant School Girls

Pregnant Kenyan school girls face discrimination in schools, contributing to high drop-out rates and low retention rates.[107] Thirteen thousand Kenyan girls leave school every year due to pregnancy,[108] constituting nearly one-third of the population of girls who drop out annually. Pregnancy and marriage have been called the greatest threats to the education of girls in Kenya.[109]

Although the Kenyan Government has addressed discrimination against pregnant school girls in several policies, including the Education Act, the 2003 Gender and Education Policy and the 2009 National School Health Policy, the measures taken have been inadequate and sometimes counterproductive. For example, the 2009 National School Health Policy seeks to address adolescent pregnancy by imposing "voluntary" pregnancy tests on female students.[110] The policy states that "[g]irls will undergo voluntary medical screening once per term."[111] These tests will be imposed throughout a student's academic career. However, advocates have raised serious concerns that in an environment where schools and teachers have "absolute power" over their students, condoning voluntary testing may be taken as endorsement of mandatory pregnancy testing.[112]

Furthermore, officials of the Ministries of Health and Education have also expressed uncertainty as to the understanding of the term "voluntary."[113] One Health Ministry official said it would be evident that those girls who do not volunteer are most likely pregnant,[114] thereby exposing them to further stigma and discrimination. A Ministry of Education official suggests that the test is *not* voluntary for school girls, but rather that school administrators have discretion on how the policy should be implemented.[115] These officials confirm that the policy gives administrators discretion to test girls upon "suspicion" of being pregnant.[116] It is well documented that upon discovery of being pregnant, girls are often expelled from school.[117] Likewise, the Chief of Health at UNICEF Kenya cautioned that "gaps in implementation" of this policy could lead to violations of girl's rights to privacy and security of the person.[118] Evidence shows that as recently as March 2012, schools girls in Kenya were still being routinely subjected to pregnancy testing and expelled if found to be pregnant, with serious consequences for their well-being.[119]

The Kenya National Association of Parents has noted that sex education in schools, rather than pregnancy testing, is the appropriate avenue for decreasing teen pregnancy.[120] Kenya has introduced the "Return to School" policy to enable young women and girls who get pregnant to return to school after delivery.[121] However, the implementation of this policy has been hampered by the fact that many schools, administrators, teachers, students and parents do not realize that it even exists.[122] This problem is compounded by the fact that academic institutions face no penalties for non-compliance with the policy.[123] There are also no official guidelines or sufficient legal backing for the implementation of the policy.[124]

Pregnant school girls are often placed in an impossible situation. They experience discrimination and harassment whether they continue or terminate the pregnancy. Procuring an abortion can also mean risking being forced out of school due to harassment from teachers and students or expulsion.[125] However, school girls in Kenya may feel compelled to obtain an unsafe abortion, as a means of continuing their education. World Bank experts have suggested "that high unsafe abortion rates may be partially attributable to the continued extra-official expulsion of pregnant students from Kenyan schools."[126]

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

1. How does the government plan to implement the recommendations from the public inquiry on reproductive health by the Kenya National Commission on Human Rights?

2. What concrete measures does the government propose to reduce deaths due to pregnancy and childbirth-related complications? What steps are being taken to ensure that health care facilities are adequately equipped to provide quality, hygienic maternal health care services and provide respectful, quality care?

3. What steps are being taken to end the ongoing practice of detaining women in health care facilities, after giving birth, because of inability to pay medical bills? What efforts have been made to ensure that essential health care services, such as delivery services, are accessible to all women without cost? What concrete mechanism has the government established to ensure that women are able to report and seek redress for discrimination, gender-based violence, abuse and detention?

4. What measures are being taken to end ongoing violations around counseling, testing, confidentiality and treatment that women living with HIV experience in health care facilities?

5. What steps has the government taken to improve access to contraceptives, and to ensure that women and adolescent girls are provided with comprehensive and accurate information about contraceptives?

6. How will the government ensure that it combats sexual violence including in schools? What efforts have been made to ensure that police appropriately respond to, and collect data regarding, incidents of sexual violence? What structures have been set up to provide services to survivors?

7. What is the government doing to end discrimination against pregnant schools girls including mandatory pregnancy testing and expulsion of pregnant school girls? Are any measures in place to provide sufficient legal backing to the 'Return to School' policy and has the government developed official guidelines to ensure that schools comply?

We respectfully suggest that the Committee consider making the following recommendations:

1. The government should demonstrate its commitment to reducing maternal mortality and morbidity by increasing the number of health care facilities that are fully equipped to provide comprehensive maternal health care services.

2. The government should specifically prohibit the practice of detention in health facilities and establish a concrete process of accountability and redress for detention and abuse in health centers, such as setting up and monitoring appropriate complaints mechanisms.

3. The government should make concerted efforts to ensure an adequate and consistent supply of contraceptives to address the prevalence of stock-outs; develop comprehensive guidelines on the obligations of all health facilities to provide accurate and comprehensive family planning services information; and establish a clear referral policy for facilities that cannot or choose not to provide certain family planning information or services.

4. In accordance with the constitutional provision stating that no person shall be denied emergency treatment, the government should specify that all health care facilities, regardless of religious affiliation, are obligated to provide emergency contraception to survivors of sexual violence.

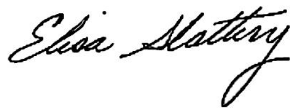
5. The government should enact tangible programs and policies to reduce the incidence of sexual violence including in schools; ensure proper data collection of known occurrences of sexual violence in schools; and demand appropriate police and government responses to instances of sexual abuse in schools.

6. The government should immediately prohibit the practice of pregnancy testing and expulsion of pregnant schoolgirls. It should provide sufficient legal backing to the 'Return to School' policy and develop official guidelines to ensure that schools comply.

7. The government should comply with the KNCHR recommendations regarding safe abortion: that the government guarantee availability of safe abortion services in all health facilities; that it ensure that abortion services are affordable; and train police officers to eliminate the arrest and harassment of both the health care providers who offer safe and legal abortion services and the women who receive the services.

We hope that this information is useful as the Committee prepares to review the Kenyan government's compliance with the Covenant. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



Elisa Slattery
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[1] Human Rights Committee, *General Comment No. 6: Right to life (Art. 6)*, (16th Sess., 1982), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 177, para. 5, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008).
[2] International Covenant on Civil and Political Rights, arts. 3 & 26, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (1966), 999 U.N.T.S. 171 *(entered into force* Mar. 23, 1976) [hereinafter ICCPR].
[3] 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 by Human Rights Treaty Bodies, at 231, para. 20, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *Gen. Comment No. 28*].
[4] *See, e.g.,* Human Rights Committee, *Concluding Observations: Argentina,* para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); *Poland,* para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).
[5] CENTER FOR REPRODUCTIVE RIGHTS, *Family Planning is a Human Right*, *in* BRINGING RIGHTS TO BEAR 9 (2008).
[6] CENTER FOR REPRODUCTIVE RIGHTS, *Preventing Maternal Mortality and Ensuring Safe Pregnancy, in* BRINGING RIGHTS TO BEAR 9 (2008).
[7] *See, e.g.,* Human Rights Committee, *Concluding Observations: Poland,* para. 11(b), U.N. Doc. CCPR/C/79/Add.110 (1999).
[8] Rep. of the Human Rights Committee, 52nd Sess., Supp. No. 40, para. 167, U.N. Doc. A/52/40 Vol. 1, (1997) [hereinafter Rep. of the Human Rights Committee (1997)].
[9] *See, e.g.,* Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CCPR/C/79/Add.104 (1999); *Poland*, para. 8, UN Doc. CCPR/CO/82/POL/Rev. 1 (2004).
[10] Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).
[11] *See, e.g.,* Human Rights Committee, *Concluding Observations: Ecuador*, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998).
[12] *See, e.g.,* Human Rights Committee, *Concluding Observations*: *Chile*, para. 15, U.N. Doc. CCPR/C/79/Add.104 (1999).
[13] UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 12-13 (2006), *available at* http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf. The reduction of maternal mortality has also been a key goal at several recent international conferences. *See e.g., Beijing Declaration and the Platform for Action, Fourth World Conference on Women,* Beijing, China, Sept. 4-15, 1995, para. 107(i),

U.N. Doc. A/CONF.177/20 (1996); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 8.21, U.N. Doc. A/CONF.171/13/Rev.1 (1995).
[14] Government of Kenya, *Consideration of reports submitted by States parties under article 18 of CEDAW: Seventh periodic reports of States parties: Kenya,* para. 180, U.N. Doc. CEDAW/C/Ken/7 (Nov. 10, 2009).
[15] NATIONAL BUREAU OF STATISTICS [KENYA], KENYA DEMOGRAPHIC AND HEALTH SURVEY 2008-09, 273 (2010) [hereinafter KDHS 2008-09].
[16] *Id*.
[17] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2010, 41 (2012). With an estimate of 360 per 100, 000 live births, the report lists a lower maternal mortality ratio for Kenya than the KDHS. *See id*.
[18] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO DELIVER: VIOLATION OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES (2007) [hereinafter FAILURE TO DELIVER]; KDHS 2008-09, *supra* note 15.
[19] FAILURE TO DELIVER, *supra* note 18, at 26-40.
[20] *Id*.
[21] KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, REALISING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR A REALITY?: A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA 48 (2012) [hereinafter KNCHR, PUBLIC INQUIRY].
[22] *Id.* at 50-54.
[23] *Id.* at 45-46.
[24] Government of Kenya, *Consideration of reports submitted by States parties under article 40 of the Covenant: Third periodic report of States parties: Kenya*, para 11, U.N. Doc. CCPR/C/KEN/3 (2011) [hereinafter Kenya Government Report].
[25] ICCPR, *supra* note 2, arts. 7, 9.
[26] *Id.* art. 17.
[27] Human Rights Committee, *General Comment No. 20: Article 7 (Prohibition of torture, or other cruel, inhuman, or degrading treatment or punishment)*, (44th Sess., 1992), *in* Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 200, para. 5, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee*, Gen. Comment No. 20*].
[28] *Id.* para.5.
[29] FAILURE TO DELIVER, *supra* note 18, at 52; Focus group discussions, unnamed participants, Nairobi, Apr.13, 2007 (on file with the Center for Reproductive Rights) ("There were women who couldn't go to the labor ward because they had not paid. They were giving birth outside.").
[30] Federation of Women Lawyers Kenya/Center for Reproductive Rights interviews and focus groups, Nov. 15, 2006, Nov. 24, 2006, Feb. 1, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 17, 2007, Apr. 20, 2007 (on file with the Center for Reproductive Rights).
[31] FAILURE TO DELIVER, *supra* note 18, at 8.
[32] Focus group discussion participant, Nairobi, March .1, 2012 (on file with the Center for Reproductive Rights).
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] KNCHR, PUBLIC INQUIRY, *supra* note 21, at 133-134, 151.
[37] Human Rights Committee*, Concluding Observations: Kenya*, para 15, U.N. Doc. CCPR/CO/83/KEN (2005).
[38] MINISTRY OF HEALTH [KENYA] ET AL., KENYA HIV/AIDS SERVICE PROVISION ASSESSMENT SURVEY 2004, 26 (2004).
[39] FAILURE TO DELIVER, supra note 18, at 54.
[40] Focus group discussion, unnamed participants, Kisumu, May 30, 2007 (on file with the Center for Reproductive Rights).
[41] FAILURE TO DELIVER, supra note 18, at 26.
[42] UNITED NATIONS POPULATION FUND (UNFPA) & WHO, SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN LIVING WITH HIV/AIDS: GUIDELINES ON CARE, TREATMENT AND SUPPORT FOR WOMEN LIVING WITH HIV/AIDS AND THEIR CHILDREN IN RESOURCE-CONSTRAINED SETTINGS 8 (2006), *available at* http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf [hereinafter SRH & HIV/AIDS GUIDELINES].
[43] Interview with Jane, Kasarani Maternity Hospital, Kasarani, June 6, 2006 (on file with the Center for Reproductive Rights). Jane, who was HIV-positive and eight months pregnant, indicated that she would deliver her baby at Kasarani Maternity Hospital, although the fee was difficult to afford.

[44] FAILURE TO DELIVER, *supra* note 18, at 13, 44.
[45] CENTER FOR REPRODUCTIVE RIGHTS, AT RISK: RIGHTS VIOLATIONS OF HIV-POSITIVE WOMEN IN KENYAN HEALTH FACILITIES 11 (2008).
[46] FAILURE TO DELIVER, *supra* note 18, at 25.
[47] KNCHR, PUBLIC INQUIRY, *supra* note 21, at 115.
[48] CENTER FOR REPRODUCTIVE RIGHTS, PREGNANT WOMEN LIVING WITH HIV/AIDS: PROTECTING HUMAN RIGHTS IN PROGRAMS TO PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV, 3 (2005), *available at* http://www.reproductiverights.org/pdf/pub_bp_HIV.pdf.
[49] WHO & UNITED NATIONS CHILDREN'S FUND (UNICEF), GUIDANCE ON GLOBAL SCALE-UP OF THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV: TOWARDS UNIVERSAL ACCESS FOR WOMEN, INFANTS AND YOUNG CHILDREN AND ELIMINATING HIV AND AIDS AMONG CHILDREN 7 (2007), *available at*http://www.who.int/hiv/mtct/PMTCT_enWEBNov26.pdf [hereinafter PMTCT GUIDANCE].
[50] SRH & HIV/AIDS Guidelines, *supra* note 42, at 31. According to PMTCT Guidance, "[t]he overall risk can be reduced to less than 2% by a package of evidence-based interventions." PMTCT GUIDANCE, *supra* note 49, at 7.
[51] GUTTMACHER INSTITUTE, FACTS ON ABORTION IN KENYA 2 (2009), *available at* http://www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf.
[52] *Id.*
[53] KDHS 2008-09, *supra* note 15, at 100.
[54] Kenya Government Report, *supra* note 24, para. 44.
[55] CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 44 (2010) [hereinafter IN HARM'S WAY].
[56] Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, INTER PRESS SERVICE NEWS AGENCY, May 18, 2009*, cited in* IN HARM'S WAY, *supra* note 55, at 45.
[57] *Id*.
[58] MINISTRY OF MEDICAL SERVICES [KENYA] ET AL., KENYA HIV/AIDS SERVICE PROVISION ASSESSMENT SURVEY 2004, 38 (2010).
[59] IN HARM'S WAY, *supra* note 55, at 44-45.
[60] Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, INTER PRESS SERVICE NEWS AGENCY, Oct. 27, 2009; IN HARM'S WAY, *supra* note 55, at 46.
[61] IN HARM'S WAY, *supra* note 55, at 47.
[62] *Id.* at 47; *see* JILL KEESBURY ET AL., MAINSTREAMING EMERGENCY CONTRACEPTION (EC) IN KENYA: FINAL PROJECT REPORT 32 (Population Council, 2009) [hereinafter MAINSTREAMING EC IN KENYA].
[63] MAINSTREAMING EC IN KENYA, *supra* note 62, at 12.
[64] IN HARM'S WAY, *supra* note 55, at 47-48.
[65] *Id.*
[66] MINISTRY OF HEALTH [KENYA], KENYA NATIONAL POST ABORTION CARE CURRICULUM: TRAINER'S MANUAL 26 (2003), *cited in* IN HARM'S WAY, *supra* note 55. Note that a Kenyan study estimated that 21,000 women are treated in public hospitals annually with abortion-related complications. More than 40% of those women "fall into the categories of probable or likely induced abortion." *See* MINISTRY OF HEALTH [KENYA], A NATIONAL ASSESSMENT OF THE MAGNITUDE AND CONSEQUENCES OF UNSAFE ABORTION IN KENYA 21 (2004). And nearly 30% experience highly severe complications. *See* Hailemichael Gebreselassie, *The magnitude of abortion complications in Kenya*, 112 BJOG: AN INT'L J. OF OBSTETRICS AND GYNAECOLOGY 1229, 1233 (Sept. 2005). These statistics demonstrate unsafe abortion's terrible toll on Kenyan women's lives and the tremendous pressure it places on an already resource-strapped health care system.
[67] Human Rights Committee, *Concluding Observations*: *Kenya*, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005).
[68] *Id.*
[69] CONSTITUTION, 2010, art. 26(4) (Kenya).
[70] The Penal Code (Rev. 2009) Cap. 63, sec. 240 (Kenya). The Ministry of Health, in its guidelines on the care of survivors of rape and sexual violence, has indicated that abortion "may be allowed" when pregnancy is a result of rape. However, the legal basis for this policy is not explicit in existing legislation. DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH [KENYA], NATIONAL GUIDELINES: MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE, 2ND EDITION 13 (2010).
[71] Human Rights Committee*, Gen. Comment No. 28*, *supra* note 3, para. 11; *see* 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, para. 2(c).

[72] KNCHR, PUBLIC INQUIRY, *supra* note 21, at 47-48.
[73] *Id.* at 72-73.
[74] *Id*.
[75] ICCPR, *supra* note 2, art. 4(2).
[76] ICCPR, *supra* note 2.
[77] *Id.* arts. 3, 9.
[78] Human Rights Committee, *Gen. Comment No. 20, supra* note 27, paras. 2, 5.
[79] Rep. of the Human Rights Committee (1997), *supra* note 8, para. 167.
[80] ICCPR, *supra* note 2, art 24.
[81] Human Rights Committee, *Gen. Comment No. 28*, *supra* note 3, para. 11.
[82] Human Rights Committee, *Gen. Comment No. 20, supra* note 27, para. 2.
[83] Human Rights Committee, *Concluding Observations*: *Kenya*, para. 11, U.N. Doc. CCPR/CO/83/KEN (2005).
[84] *Id*.
[85] Renson Mnyamwezi, *NGO decries rise in rape cases*, THE STANDARD, April 23, 2009, at 9, *cited in* IN HARM'S WAY, *supra* note 55, at 42.
[86] *Id*.
[87] Michelle J. Hinden et al., *Intimate Partner Violence Among Couples in 10 DHS Countries: Predictors and Health Outcomes* xi (United States Agency for International Development, 2008), *cited in* IN HARM'S WAY, *supra* note 55, at 42.
[88] *Id*.
[89] KNCHR, PUBLIC INQUIRY, *supra* note 21, at 75. The KNCHR relied on the 2008-2009 KDHS for the data about women's first sexual encounters.
[90] The Sexual Offences Act (2006) No. 3, sec. 38 (Kenya).
[91] MINISTRY OF HEALTH [KENYA], NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 13 (2nd ed., 2009).
[92] In Harm's Way, *supra* note 55, at 34.
[93] *Id.* at 43.
[94] HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS (2001).
[95] *Id*.
[96] Sara Jerop Ruto, *Sexual Abuse of School Age Children: Evidence from Kenya*, 12(1) J. OF INT'L COOP. IN EDUC. 171, 174 (2009).
[97] Joy Wanja, *Teenage Sex Study Shock for Parents*, DAILY NATION, Oct. 13, 2009, *available at* http://www.nation.co.ke/News/-/1056/671974/-/unyogd/-/index.html.
[98] Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION, Nov. 1, 2009, *cited in* IN HARM'S WAY, *supra* note 55, at 42.
[99] *Id*.
[100] *Id.*
[101] Fatuma Chege, *Education and Empowerment of Girls against Gender-based Violence*, 10(1) J. OF INT'L COOP. IN EDUC. 53, 61 (2006).
[102] KENYA ALLIANCE FOR ADVANCEMENT OF CHILDREN, ET. AL., STATE VIOLENCE IN KENYA: AN ALTERNATIVE REPORT TO THE UNITED NATIONS HUMAN RIGHTS COMMITTEE 104 (2005) [hereinafter STATE VIOLENCE IN KENYA].
[103] Daniel Wesangula, *New School Guidelines to Protect Students Against Sex Pest Teachers*, DAILY NATION, May 1, 2010, *available at* http://mobile.nation.co.ke/News/New+guidelines+to+protect+pupils+against+sex+pest+teachers+/-/1290/910278/-/format/xhtml/item/6/-/qi9n1b/-/index.html.
[104] STATE VIOLENCE IN KENYA, *supra* note 102, at 71.
[105] Teacher's Service Commission [Kenya], Circular No. 3/2010 (Apr. 29, 2010) *available at* http://www.tsc.go.ke/circulars/CIRCULAR%20%20ON%20SEXUAL%20ABUSE.pdf.
[106] *Id.*
[107] CENTRE FOR THE STUDY OF ADOLESCENCE, DOWN THE DRAIN: COUNTING THE COSTS OF TEENAGE PREGNANCY AND SCHOOL DROP OUT IN KENYA 8, 29 (2008)[hereinafter DOWN THE DRAIN].
[108] Kwamboka Oyaro, *Teenage Mothers Denied Education*, INTER PRESS SERVICE NEWS AGENCY, May 23, 2010 *available at* http://ipsnews.net/africa/nota.asp?idnews=42487.

[109] Cynthia Vukets, *Testing School Girls for Pregnancy Not Likely to Cut Number of Teenage Mothers*, DAILY NATION, Dec. 22, 2009, *available at* http://www.nation.co.ke/News/-/1056/829400/-/view/printVersion/-/rmhek5z/-/index.html.
[110] *Id.*
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.* Suspicious signs include "girls sleeping in class, being choosy about food or vomiting."
[117] IN HARM'S WAY, *supra* note 55, at 53.
[118] Vukets, *supra* note 109.
[119] Reuben Olita, *Teso School Expels Four Girls Over Pregnancy*, THE STAR, MAR. 5, 2012, *available at* http://allafrica.com/stories/201203060037.html.
[120] *Id.*
[121] DOWN THE DRAIN, *supra* note 107, at 42.
[122] Oyaro, *supra* note 108.
[123] DOWN THE DRAIN, *supra* note 107, at 8.
[124] *Id.* at 42.
[125] IN HARM'S WAY, *supra* note 55, at 56.
[126] Ellen M. H. Mitchell et al., *Social scripts and stark realities: Kenyan adolescents' abortion discourse*, 8(6) CULTURE, HEALTH & SEXUALITY 515, 518 (Dec. 2006).