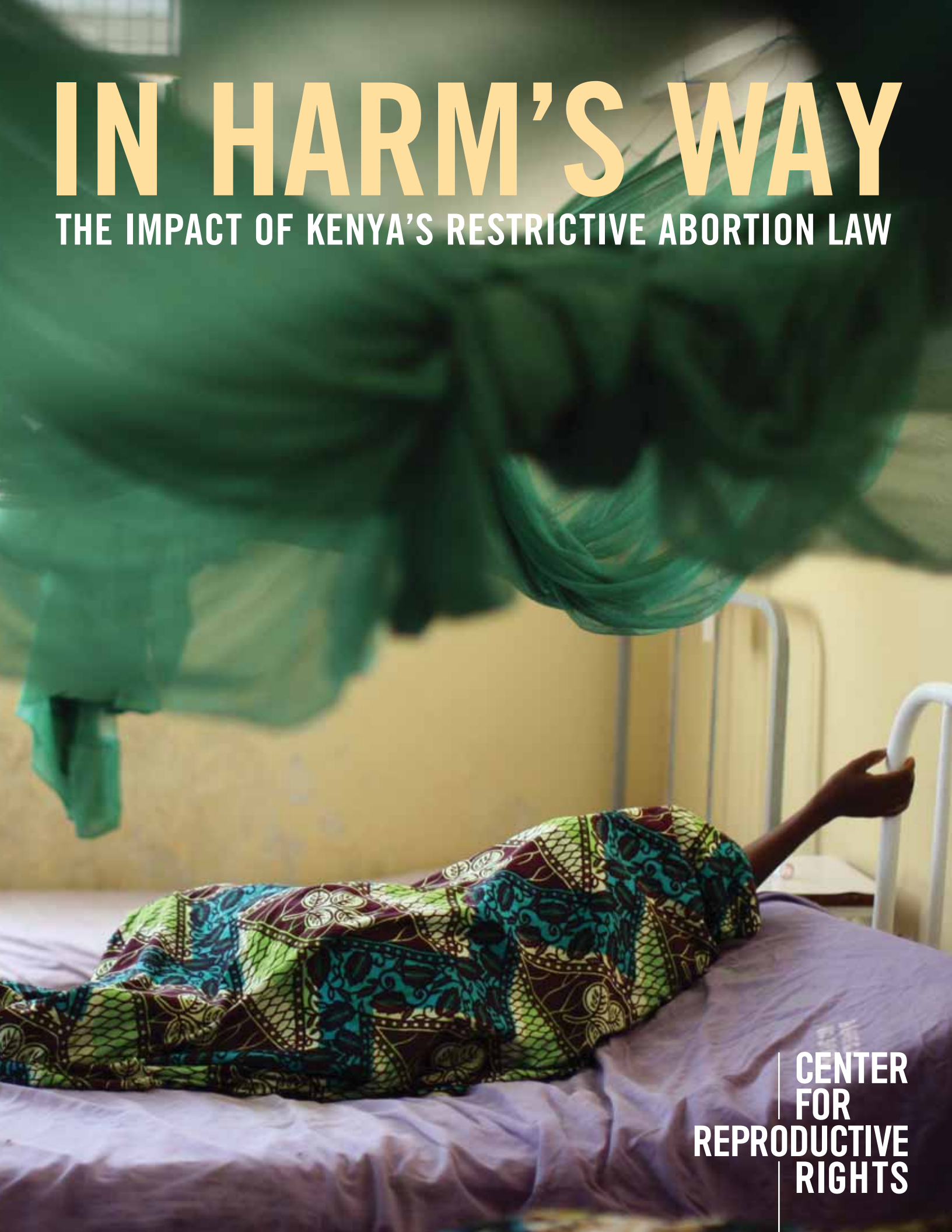
IN HARM'S WAY

THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW



CENTER FOR REPRODUCTIVE RIGHTS

IN HARM'S WAY

THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW

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Foreword

Every year, at least 2,600 women die from unsafe abortion in Kenya; 21,000 more women are hospitalized annually with complications from incomplete and unsafe abortion, whether spontaneous or induced. As grim as these numbers are, they do not capture the number of women killed or disabled by unsafe abortions who never visit a health facility or whose cause of death is not recorded.

Even these numbers are unacceptably high, both in absolute terms and comparatively. Unsafe abortion is responsible for 30-40% of maternal deaths in Kenya, far more than the worldwide average of 13%. Kenya's abortion case fatality rate is also higher than the estimated rate for the African continent. Unsafe abortion is a serious public health problem in Kenya that we can no longer afford to ignore. Fortunately, it is a problem that can be easily solved: by making safe abortion services available and accessible.

As an obstetrician-gynecologist and head of the OB/GYN Department at Kenyatta National Hospital, I have seen firsthand how Kenya's restrictive abortion law devastates women's lives and health, affecting poor women and adolescents most acutely. Patients suffering from abortion complications arrive in the wards daily; some experience serious complications and—more often than not—do not survive. Others, some only adolescents, undergo hysterectomies or suffer lifelong complications, such as chronic pelvic pain or intestinal obstruction. The lives of women and girls, and those of their families and children, are forever changed by the consequences of unsafe abortion.

In addition to the personal losses associated with unsafe abortion, the public healthcare system is severely burdened by the effects of the restrictive abortion law. Our system is ill equipped—lacking in trained staff, supplies, equipment, and appropriate regulation—to provide adequate and quality post-abortion care services to the thousands of women in need. The burden is felt beyond those patients with complications from abortion: scarce public resources are being diverted from other obstetrical and gynecological emergencies or health priorities to address the serious problem of unsafe abortion.

Unsafe abortion is more than a public health concern, however; it is also a human rights issue. As this report documents, Kenyan women are denied access to a simple and safe medical procedure that only women need and face serious and multiple barriers to obtaining quality post-abortion care. Forcing women to resort to unsafe abortion causes immeasurable physical and mental suffering and violates fundamental human rights to life, health, and dignity. The government's failure to address the causes and consequences of unsafe abortion places women in harm's way.

Studies have shown that restrictive abortion laws do not prevent abortions; instead, they prevent access to safe abortion. Limiting access to this procedure is devastating for women's lives and health, for women's families and communities, for the health care system and—ultimately—for the country.

Dr. Njoroge Waithaka
Chairman, Kenya Obstetrical and Gynecological Society (KOGS)

Executive Summary

> *I have seen so much misery at the Kenyatta National Hospital . . . where women with abortion-related problems have died and others lost uteruses. There is no doubt the existing laws are colonial and too strict in the modern society.*[i]
>
> ***—Professor Julius Meme, Permanent Secretary in the Kenyan Ministry of Health, 1999***

Unsafe abortion claims the lives of thousands of Kenyan women each year. Their deaths are entirely—and easily—preventable. Yet the Kenyan government has done little to address the problem. Kenya's abortion fatality rates are substantially higher than in the African region as a whole and more than nine times higher than for developed regions. It is not a coincidence that Kenya's abortion law is also one of the most restrictive in the world.

Studies have long demonstrated the correlation between a country's restrictive abortion law and high rates of maternal mortality. Where access to safe and legal abortion is limited, women resort to unsafe abortion, with devastating consequences for their health, lives, and families. This report documents these consequences in Kenya, highlighting how the country's restrictive legal and policy regime, coupled with the Kenyan government's failure to effectively address the root causes leading to unwanted pregnancies, leaves women squarely in harm's way. Although this report focuses on Kenya, the problem of unsafe abortion in restrictive and unclear legal and policy environments is far from unique. Many Commonwealth African countries that have not reformed their abortion laws confront the same issues detailed in this report, including the devastating effect of unsafe abortion on women and their families, the lack of clarity in abortion laws and policies, and inadequate training in safe abortion and post-abortion care.

The findings documented in this report are not new—the Kenyan government, medical practitioners, and women and their families have long felt the impact of Kenya's restrictive abortion law. However, this report offers the first comprehensive look from a human rights perspective at the corrosive effects of criminalizing abortion in Kenya. The rights violations documented in this report make clear that the lack of access to safe abortion is not only responsible for the deaths and health burdens of thousands of women, but also seriously undermines the quality of care both provided and received in Kenyan healthcare facilities. It further demonstrates the toll the law has on the lives of healthcare providers and on their ability to effectively and ethically comply with the dictates of their profession: to save the lives and protect the health of their patients. Finally, the overwhelming resource burden placed on the healthcare system by the number of patients seeking post-abortion care can be traced directly to Kenya's restrictive abortion law.

These findings are particularly relevant at a time when Kenya is poised to introduce language into its proposed new constitution that may restrict access to safe abortion even further. Possible language in the Bill of Rights could include provisions stating that "the life of a person begins at conception" and "abortion is not permitted unless in the opinion of a registered medical practitioner, the life of the mother is in danger." *In Harm's Way: The Impact of Kenya's Restrictive Abortion Law* makes abundantly clear that restrictive abortion laws do not prevent women from having abortions. Instead,

prohibitions on access to abortion simply prevent women from having safe abortions and severely undermine the quality of abortion and post-abortion care services provided to women in need. They further place an enormous burden on a healthcare system that is poorly equipped to handle the number of women requiring post-abortion care, a healthcare service that is stigmatized, and therefore neglected, as a consequence of the criminalization of abortion.

Constitutions, particularly their Bill of Rights, are rights-affirming documents that seek to provide a framework within which all members of society can have their rights protected, promoted, and respected. Prohibiting a medical procedure that only women need fails to recognize women as full members of society, with equal rights to life, health, equality, dignity, and freedom from torture and cruel, inhuman, or degrading treatment, among others. In addition, constitutional language stating that life begins at conception is directly at odds with international human rights law. International and African regional human rights treaties and the official bodies that interpret their provisions do not extend "right to life" protections to fetuses. Furthermore, they support the position that recognizing the right to life from conception would interfere significantly with women's basic human rights.

Background to this Report

The Center for Reproductive Rights (the Center) has been working on issues related to Kenyan healthcare for several years and, in two previous human rights fact-finding reports, has documented violations of women's human rights with respect to women's experiences with family planning, pregnancy, and childbirth in Kenyan healthcare facilities as well as the barriers to quality healthcare experienced by women living with HIV. These reports have laid the foundation for understanding the complexities of Kenya's healthcare system as well as its strengths and weaknesses. *In Harm's Way* clearly demonstrates that the weaknesses in Kenya's healthcare system documented in these reports are further exacerbated when it comes to a medical procedure that is perceived as illegal and heavily stigmatized.

The information in this report is based on research and interviews conducted by the Center between June 2009 and February 2010. The Center gathered the experiences of 59 women through a combination of in-depth interviews and focus group discussions. The Center also conducted site visits to private and public healthcare facilities and spoke to healthcare providers and administrators. Leaders and reproductive health focal points of medical associations, officials at health professionals' licensing and regulatory bodies, officials at the Ministry of Health's Division of Reproductive Health, leaders of organizations focused on training providers to offer abortion-related services, and professors and lecturers at provider training schools were also interviewed for this report. In addition, the Center reviewed government guidelines, standards, and manuals on issues pertaining to reproductive health services, with a particular focus on abortion and post-abortion care, and media coverage of abortion-related issues in Kenya over the past few years. Finally, data from public health studies on abortion in Kenya were also used to provide a broader context and supplement the information gleaned from interviews and media reports.

Report Findings

Unsafe abortion is a major public health crisis in Kenya, accounting for 35% of Kenya's maternal deaths. Unsafe abortion is defined by the World Health Organization as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking

minimal medical standards or both." That definition, however, fails to capture the full range of painful, dangerous, and often lethal methods used when women are unable to safely terminate a pregnancy, including inserting catheters, crochet or knitting needles, sticks, pipes, coils, wires, and pens; ingesting bleach, concentrated tea, detergent, and herbs; overdosing on malaria pills; and inflicting deliberate bodily injury upon themselves.

As a consequence of being forced to resort to these crude methods, over 2,600 women die annually in Kenya from complications of unsafe abortion. Approximately 21,000 women are admitted each year to Kenya's public hospitals for treatment of complications from incomplete and unsafe abortion, spontaneous or induced. More than 40% of those women "fall into the categories of probable or likely induced abortion." One study conducted in two informal settlements in Nairobi found that more than 50% of abortion fatality cases "do not seek care even in the event of a complication after the abortion." However, these statistics are likely underestimates: the World Health Organization notes that "[more than any other aspect of sexual and reproductive ill-health, abortion suffers from gross under-reporting."

These high rates of morbidity and mortality from unsafe abortion are due to Kenya's restrictive abortion law and the rights violations and abuses that stem from the criminalization of abortion. The devastating impact of the law on women's lives and health is also the consequence of rights violations experienced by Kenyan women that lead to unwanted pregnancies. According to the 2003 Kenya Demographic and Health Survey (2003 KDHS), "nearly 20 percent of births in Kenya are unwanted and [an additional] 25 percent are mistimed (wanted later)." High rates of sexual violence, limited access to family planning services and information, poverty, and discrimination against pregnant adolescents in Kenyan schools are key factors leading to unwanted and unplanned pregnancies and, consequently, unsafe abortion in Kenya.

Barriers to Safely Terminating a Pregnancy

Kenya's abortion law is both restrictive and unclear, further complicating access to safe abortion. The Penal Code generally prohibits the performance of an unlawful abortion but further stipulates that a person will not be held criminally responsible for performing an abortion if done for the preservation of the woman's life. In addition, there have been more expansive interpretations of this exception issued by the Ministry of Health and the Medical Practitioners and Dentists Board, allowing for abortions to be lawfully performed in cases of risk to the woman's health or in some cases of rape. Yet, few healthcare providers are trained on the full content of the law and most women remain unaware of the law's exceptions. A lack of clarity about legal access to abortion has produced widespread misinformation among women, adolescents, and medical providers.

As a result, in Kenya, a woman who wants to safely terminate an unwanted pregnancy must negotiate a maze of misinformation as well as personal, financial, and bureaucratic barriers. Women face multiple obstacles to obtaining a safe abortion in Kenya, due largely to the stigma, lack of legal clarity, and prohibitive costs surrounding the procedure. Women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe abortion services. Although Kenyan women with financial means usually have access to relatively safe abortions performed by private practitioners, most poor women must resort to unsafe and clandestine means. Women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya's public healthcare system.

Healthcare providers, both inadvertently and deliberately, sometimes impede access to safe and legal abortion services. In public hospitals in particular, providers often may not discuss abortion as an option when counseling women who qualify for a legal abortion. Some providers may refuse to perform a legal termination when requested—either due to a misunderstanding of the law or for personal reasons—or delay the scheduling of the procedure in an effort to dissuade women from terminating. If a woman wishes to contest her provider's denial of care, or any mistreatment she is subject to by her provider, there are few avenues for redress. In addition, women face structural barriers to access in both public and private healthcare facilities: abortion services may be difficult to obtain due to a lack of provider training or necessary medical equipment.

The Harmful Consequences of Denial of Access to Safe and Legal Abortion

Procuring an abortion in Kenya, whether safe or unsafe, carries social and legal risks for women, such as stigma and social condemnation as well as arrest and prosecution. Women or girls may be ostracized by their families and communities or risk losing their opportunity to complete their education. Further, women who procure an abortion risk being reported to officials by their neighbors and families and being arrested. Girls and women charged with procuring an unlawful abortion rarely have legal representation and typically plead, and are found, guilty.

Some women, denied access to safe and legal abortion and unwilling to risk the consequences of unsafe and illegal abortion, are forced to carry an unwanted or unplanned pregnancy to term. This has serious implications for her mental and physical health and her ability to realize other fundamental human rights. It can also determine the extent to which a woman can realize her potential and participate in both private and public life. International and regional human rights bodies have acknowledged that being forced to carry a pregnancy to term violates women's human rights, including the right to be free from cruel, inhuman, or degrading treatment.

Still other women are forced to resort to unsafe abortion, often requiring post-abortion care for the resulting health complications, many of which are life-threatening. Yet, just as women encounter multiple barriers to safe abortion services, women requiring post-abortion care must also overcome a series of obstacles to access care at a healthcare facility and to obtain quality care from the healthcare providers on duty. Hurdles to access include the fear of prosecution and social stigma and the prohibitive costs associated with obtaining post-abortion care. Those who cannot afford the medical bill for post-abortion care services may find themselves detained in healthcare facilities, held by the hospital administration against their will until they find the requisite funds or until it is clear they cannot pay. These official costs, unaffordable in and of themselves, are compounded by the pervasive practice of providers soliciting bribes from patients in exchange for care. Women interviewed for this report consistently raised bribery as both an obstacle to and requirement for obtaining post-abortion care. Women reported being denied care until they paid the solicited bribe and explained that providers also threatened to turn them into the police unless they paid the asked-for sum.

Impediments to quality post-abortion care range from a lack of trained staff capable of offering post-abortion care, provider reluctance to offer care due to the fear and stigma associated with providing these services, the pervasive solicitation of bribes, negative provider attitudes and related verbal abuse, and inadequate pain management. Women and providers interviewed for this report often raised the issue of the harassment of post-abortion care patients by providers. One provider reported overhearing a nurse tell a woman, "You had sex, you had your excitement. Now you're crying, who will help you?

We will just leave you to die." As with denials of access to a legal abortion, there are few avenues for redress for women who experience abuses during the provision of abortion-related healthcare services.

It is clear that the Kenyan public healthcare system is poorly equipped to handle the high rates of unsafe abortion cases presenting in government facilities. Due to a combination of a lack of resources, failure to prioritize training and equipment for post-abortion care and abortion services, limited guidance from the government about what is permitted under the law and who is permitted to offer services, and the stigma and fear stemming from the criminalization of abortion, abortion-related healthcare services do not meet the population's needs. Although the Ministry of Health claims that post-abortion care is a priority area for the government and has made improvement of post-abortion care a key component of its current national reproductive health strategy, it has not devoted the resources, attention, or institutional support to strengthening post-abortion care services to reflect that fact.

Access to abortion-related services is further hindered by a lack of clarity concerning clinical officers' and nurses' scope of practice in Kenya, which stems from the stigma and criminality associated with abortion. There are mixed signals from professional regulatory bodies, academic institutions and training instructors, and the Ministry of Health on whether these two cadres of healthcare providers are permitted to offer safe abortion services. Nurses are additionally uncertain as to whether they may offer post-abortion care. This confusion complicates effective service provision and is particularly problematic as these providers have the greatest geographical and population reach of all the healthcare providers in Kenya and are often on the front lines of service provision in rural or underserved areas.

Beyond the Impact on Women: Healthcare Providers and the Healthcare System

Healthcare providers who offer post-abortion care or abortion services are also significantly affected by Kenya's restrictive abortion law in both their professional work and their personal lives. Providers and their families encounter police and community harassment, are forced to pay bribes to police, are criminally prosecuted, face employment discrimination due to the stigma surrounding abortion, and struggle with the internal personal and professional tension that the law creates, pitting their duty to save lives and promote health against their obligation to obey the law.

In addition, the cost of unsafe abortion to Kenya's healthcare system is substantial. Kenyan gynecologist J.K.G. Mati has suggested that "a very conservative estimate of the annual cost to Kenya [of the management of botched abortion] is of the order of 250–300 million shillings [$3.3–4 million approximately]." Treating complications from unsafe abortion significantly strains the already limited funds, staff, and medical supplies available to Kenya's public health system, diverting scarce resources to an easily preventable public health problem. Gynecology wards and maternal health-related services experience this financial impact most acutely. A report by International Planned Parenthood Federation, for example, concluded that "[t]he impact [of unsafe abortion] on the resources of Kenya's healthcare system is enormous, with as much as 60 per cent of the resources of Kenyatta National Hospital's maternity ward taken up by victims of unsafe abortions."

The considerable burden of unsafe abortion on the healthcare system, providers, and women is largely a function of Kenya's restrictive abortion law. In addition to forcing women to resort to unsafe abortions—and thereby creating the high demand for post-abortion care—criminalizing abortion also drives up the cost of abortion services and can cause women to wait until their second trimester,

when they have saved up enough money, to seek termination services. This practice is accompanied by greater complications, longer hospital stays, and, inevitably, greater use of the health system's resources. Further, women often do not seek timely post-abortion care due to fear of arrest, a lack of knowledge about services, stigma, and the often-prohibitive cost of post-abortion care. These delays extend women's suffering and increase the severity of the complications, requiring more resources and extended hospital stays.

The criminalization of abortion in Kenya has created an environment in which unsafe abortion has become a public health crisis that most healthcare administrators and policymakers are content—and permitted—to ignore. Ultimately, reducing the cost burden to both women and the healthcare system of unsafe abortion is simply a matter of providing safe, accessible abortion services.

Human Rights Violations in the Context of Abortion and Post-Abortion Care

The findings of this report have more than just public health implications. They also reveal serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the right to life; the right to health; the right to liberty and security of person; the right to be free from torture and cruel, inhuman, or degrading treatment; the rights to equality and non-discrimination; the right to dignity; the right to information; the right to privacy and family; and the right to redress and legal assistance. The violations described in this report demonstrate that Kenya is not honoring its domestic and global commitments to respect, protect, and fulfill these rights.

In addition, access to safe abortion has been explicitly recognized as central to protecting women's human rights. Article 14 of the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol), which Kenya has signed, outlines a woman's right to abortion in a range of circumstances: "States Parties shall take all appropriate measures to . . . protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus . . ."

Recommendations

> *Those of us who have worked in our hospitals are aware of the vast numbers of women and girls who end up in our casualty wards. . . . What is the grim side of this story is that many of these victims of criminal abortions suffer irreparable damage to their [re]productive systems as a result of infection. . . . [I]mpressions gained through the experiences of hospitals tend to show that the problem is real and should be give serious consideration now . . . the question of legalizing abortion should be given appropriate consideration if only for averting known miseries, and sometimes death, of many girls and young women in their best years of life.*[ii]
>
> ***—Dr. S. Kanani, Deputy Director of Medical Services, 1976***

> *The findings of the study show very high rates of abortion-related complications associated with a considerable cost burden to the health-care system. Kenya can ill-afford these high costs while also trying to meet basic maternal and child health needs. . . . This study highlights the need to intensively scale-up abortion care services on a national level and decongest tertiary facilities, which are also Ministry of Health objectives.*[iii]
>
> ***—Dr. James Nyikal, Director of Medical Services, Ministry of Health, Foreword to Study on Unsafe Abortion in Kenya, 2004***

As demonstrated by these quotes, separated by more than a quarter century, the toll of unsafe abortion on Kenyan women and the Kenyan healthcare system has long been acknowledged. We urge the Kenyan government to back its stated commitment to improving and protecting women's reproductive health with the necessary actions. A crucial step in addressing unsafe abortion is reviewing the existing abortion law and bringing it into accord with international human rights standards. The government should consider removing abortion from the penal code entirely or, at a minimum, amending the law to explicitly state that abortion is legal in cases of sexual violence and where the physical and mental health of the pregnant woman is threatened, which would harmonize the law and existing policies and regulations.

We also strongly urge the Kenyan government to address the problem of unwanted and unplanned pregnancies. Necessary steps include improving contraceptive access, removing barriers to emergency contraception in particular, and providing comprehensive, evidence-based sexuality education. The Kenyan government should also ensure access to safe abortion services when permitted under the law by, among other things, informing and educating the public about the right to safe and legal abortion, ensuring the development and endorsement of safe abortion guidelines and clear referral policies, requiring comprehensive abortion care training for all providers, and remedying equipment and staffing problems that impair the provision of safe abortion services.

In addition, the government should also improve the accessibility and quality of post-abortion care services, including by making clear to providers and women that women have the right to quality post-abortion care at all healthcare facilities, making post-abortion care a free service or at a minimum standardizing and making transparent post-abortion care fees across public health facilities, eliminating the practice of detaining patients who cannot pay, ensuring that staff are comprehensively trained in the provision of post-abortion care, and maintaining the necessary equipment and supplies in all healthcare facilities. The Kenyan Parliament should also strive to strengthen Kenya's human rights framework by domesticating conventions already ratified and ratifying and domesticating the Maputo Protocol.

Finally, we urge the international donor community to actively support advocacy efforts to improve access to safe and legal abortion services and quality post-abortion care and to increase funding for post-abortion care programs, including training and equipment purchasing.

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[i] Ipas, *Abortion and Human Rights in Sub-saharan Africa*, 3(2) Initiatives in Reproductive Health Policy (July 2000).

[ii] Rebecca Cook and Bernard Dickens, *Abortion Laws in African Commonwealth Countries*, 25(2) Journal of African Law at 60 (1981).

[iii] Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya at v (2004).

Methodology and Structure of the Report

Methodology

The information in this report is based on research and interviews conducted by the Center for Reproductive Rights (the Center) between June 2009 and February 2010. The Center gathered the experiences of 59 women through a combination of in-depth interviews and focus group discussions. To protect their confidentiality, women's real names are not used in this report. This report also draws upon the research and interviews conducted between November 2006 and May 2007 for *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, which was jointly published by the Federation of Women Lawyers—Kenya and the Center for Reproductive Rights.

The women whose voices are reflected in this report range in age from 18 to 60. They are single and married, some are mothers of ten, some are without children, and some were pregnant at the time of the interviews. They come from a variety of ethnic groups. They include poor women living in informal settlements to middle-class women; the educational levels of the women range from primary school to advanced degrees. Some of the women had unsafe abortions, a few had obtained safe abortions, and others knew of friends and family who had procured an abortion. Information was gathered from women currently living in and around Nairobi, Nyanza and Coast provinces, in both rural and urban areas. Participants recounted experiences in a range of facilities, from private clinics to district, provincial, and national public hospitals to backstreet, unlicensed clinics. Interviewees and focus group participants were identified through healthcare providers and community-based organizations.

The Center also conducted site visits to private and public healthcare facilities and spoke to healthcare providers, including doctors, nurses, clinical officers, pharmacists, community health workers, a rape trauma counselor, and administrators. Due to concerns for some healthcare providers' security, their quotes are not attributed to them by name. The Center further spoke with leaders and reproductive health focal points of medical associations; officials at licensing and regulatory bodies, including the Medical Practitioners and Dentists Board, the Nursing Council of Kenya, the Clinical Officers Council; and the Ministry of Health's Division of Reproductive Health's maternal newborn health program officer, gender and reproductive rights program manager, and head. Finally, the Center interviewed leaders of organizations that train providers to offer abortion-related services and professors and lecturers at provider training schools.

Additionally, the Center reviewed government guidelines, standards, and manuals on issues pertaining to reproductive health services, with a particular focus on abortion and post-abortion care, and media coverage of abortion-related issues in Kenya over the past few years. Data from the 2003 Kenya Demographic and Health Survey and the 2004 Kenya Service Provision Assessment Survey has been used both to provide a national perspective on reproductive health and to corroborate specific rights violations. Various public health studies on abortion in Kenya were also used to provide a sense of the magnitude and nature of the problem of unsafe abortion. However, due to the stigma and fear fueled by Kenya's restrictive abortion law, accurate data on abortion and post-abortion care is difficult to obtain and current statistics vastly underestimate the scale of the problem.

The stigma and fear surrounding abortion in Kenya was also a challlenge in researching this report. Many women, government officials, and providers proved unwilling to speak with us—or speak openly—about abortion. Bureaucratic red tape posed additional barriers to accessing public health institutions and speaking with their employees. In addition, the lack of published magistrate's opinions and of centralized databases or archives containing court decisions made finding legal decisions pertaining to abortion difficult. Finally, the underreporting of abortion data, common in a restrictive legal environment, made locating accurate and comprehensive data relating to abortion or post-abortion care in Kenya difficult.

Scope and Structure of the Report

This report focuses on how the legal and policy framework surrounding abortion, which fails to ensure access to safe abortion, harms women's health and lives and negatively affects healthcare providers and the healthcare system in Kenya.

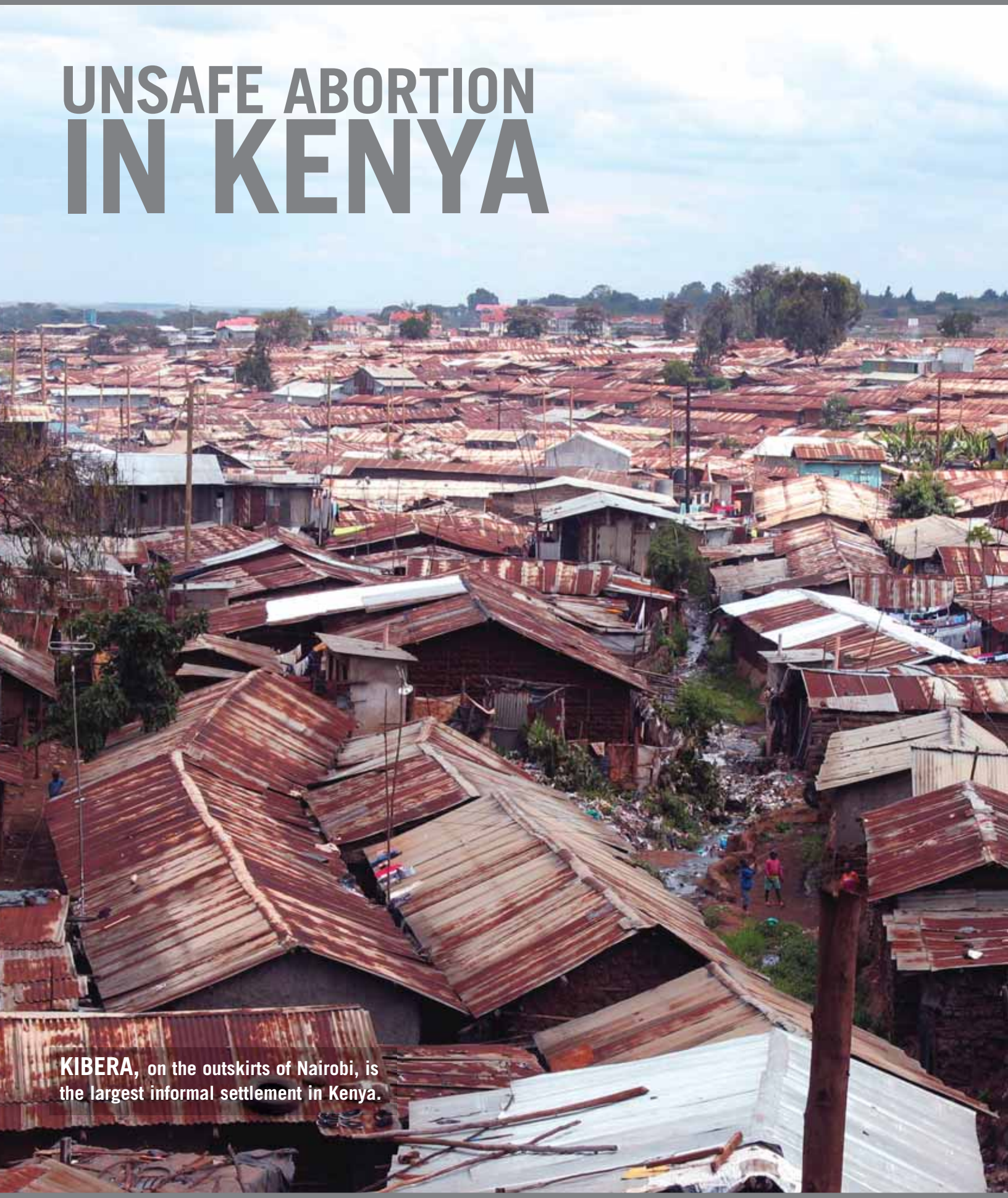
The report opens with a case study on the death of a young woman from unsafe abortion, followed by Section Two, an overview of the toll of unsafe abortion, including the methods women use to terminate unwanted pregnancies. This is followed by Section Three, a case study examining the impact of Kenya's restrictive abortion on providers. Section Four provides the legal and policy framework for abortion in Kenya, including a brief inset containing the key laws, cases, and policies pertaining to abortion for easy reference.

The following four sections provide insight into a woman's experience with unwanted pregnancy and the obstacles she faces in accessing safe abortion and post-abortion care. Section Five provides a discussion of the human rights violations leading to unwanted pregnancies, including an inset that highlights the particular discrimination experienced by pregnant girls in Kenyan schools. Section Six analyzes the barriers women and girls face when seeking to safely terminate a pregnancy, while Section Seven highlights the social and legal risks of procuring an abortion in Kenya, followed by an inset that discusses the rights implications of being forced to carry a pregnancy to term. Section Eight then analyzes the obstacles and barriers to seeking and obtaining post-abortion care for women who have been forced to procure an unsafe abortion, and includes an inset on detention of patients in healthcare facilities.

Section Nine explains some of the reasons why women receive such poor quality abortion-related services, discussing systemic issues in the provision of abortion and post-abortion care services. Section Ten looks beyond the impact on women, to address the impact of Kenya's restrictive abortion law on healthcare providers and the healthcare system and includes a brief inset on unsafe abortion's cost to Kenya's healthcare system. Finally, Section Eleven provides an overview of the international legal implications of the rights violations identified in the report.

Recommendations to key stakeholders, based on input from the women, medical providers, and officials with whom the Center spoke, are included at the end of the report.

UNSAFE ABORTION IN KENYA



KIBERA, on the outskirts of Nairobi, is the largest informal settlement in Kenya.

Sarah's Story

Sarah was 14 years old when she died from complications from unsafe abortion. She lived in a one-room shack in the heart of Kibera—Kenya's largest informal settlement—with her mother, four siblings and two nieces. Her father had died of AIDS and tuberculosis. Her mother, Evelyne, is HIV-positive and was hospitalized for two years with tuberculosis complications, suffering spinal damage; she was wheelchair bound for months after discharge and has permanent limited mobility.

Sarah left school at age 13 to support her family. When she couldn't find work washing clothes for other women, she would have sex with men. These men typically refused to pay for sex unless it was "flesh to flesh"—without a condom. She would use the 100 Kenyan shillings ($1.30) earned from these encounters to buy food for the family.

When Sarah became pregnant, another woman in Kibera advised her to get an abortion. Sarah told her mother she was going to visit her aunt and, instead, procured an unsafe abortion from the woman's friend. Afterwards, Sarah developed a dangerous, life-threatening infection that left her in great pain and bedridden for a month. Upon hearing of Sarah's condition, the woman who advised her fled the area.

The cost of emergency healthcare and the fear of arrest kept Sarah from seeking medical care. Only when the infection had progressed significantly did her mother discover the extent of her condition. The only care she received was her mother's attempts to wash the wound with Dettol, a disinfectant.

Sarah and her mother were afraid to talk to anyone about how sick she was because of the risk of arrest and the fear of community condemnation. They could not raise the money to take her to the hospital because, unlike with other emergencies or illnesses in Kenya where poorer communities rally to help their own, no one would contribute if they knew it was for complications of abortion. Sarah's post-abortion care would have cost less than 2,000 shillings ($26).

Sarah died at home on June 29, 2009. Her family now goes for days without food and survives on handouts from neighbors. The landlord is threatening to evict her family from their one-room shack because they cannot afford the 800 shillings ($10) monthly rent. It is unclear where they will go or how they will live once evicted from Kibera.[1]

THE TOLL OF UNSAFE ABORTION ON WOMEN'S HEALTH AND LIVES

Resorting to Unsafe Abortion: Painful and Dangerous Methods Used to Terminate Unwanted Pregnancies

They mostly have had foreign things inserted. Metal wires, knitting needles. Concoctions—they drink something they buy from the herbalist. Some drink Omo detergent. They take anything. Some take anti-malarials, forgetting that while it may get rid of the fetus it may also harm their own health.[2]

— Nurse-midwife

Unsafe abortion is defined by the World Health Organization as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both."[3] That definition, however, fails to capture the full range of painful, dangerous, and often lethal methods used when women are unable to safely terminate a pregnancy. The following is a list of methods used by women in Kenya, based on interviews for this report.

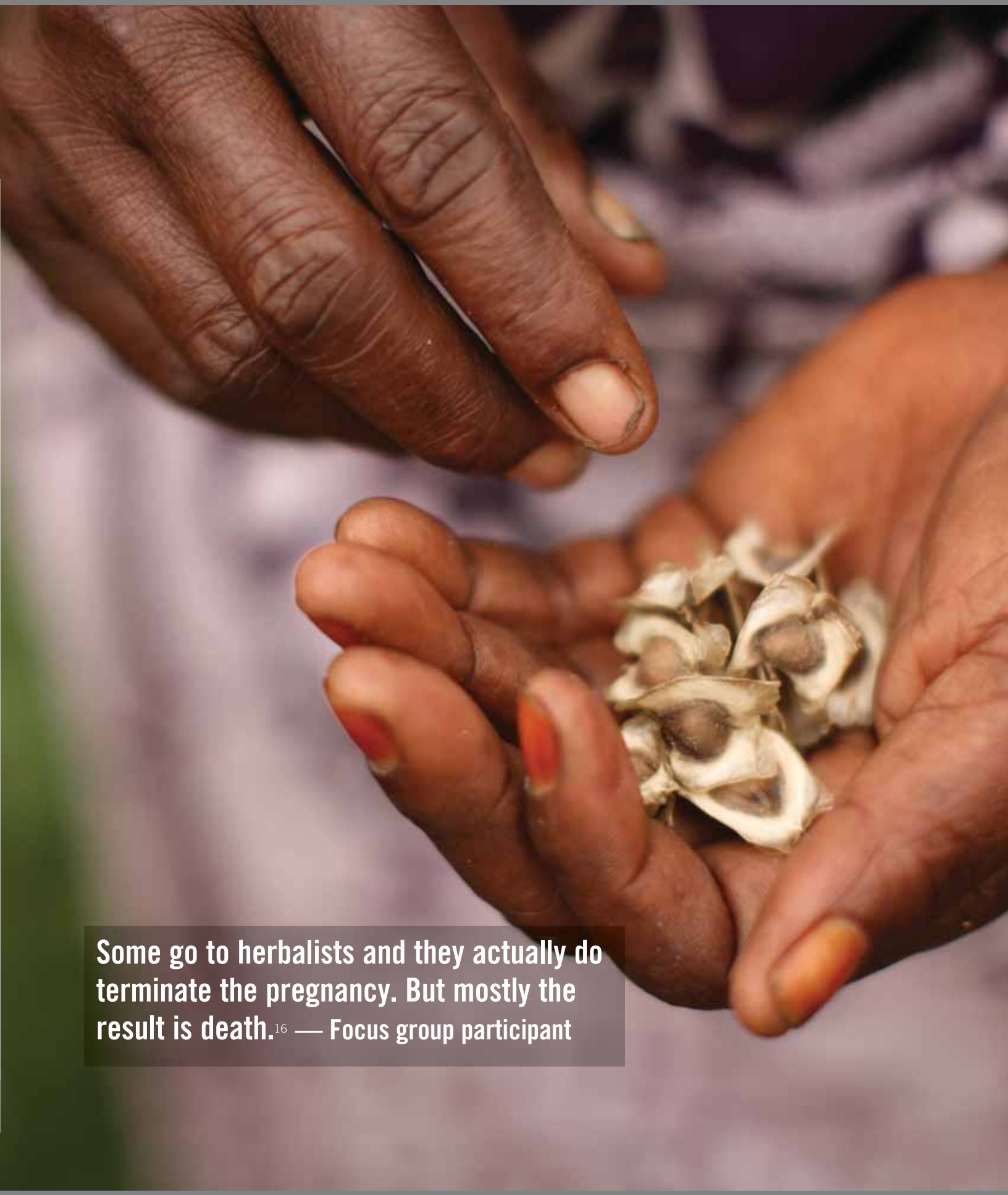
Some methods include the insertion of various objects:

- **catheters**[4]
- **crochet or knitting needles**[5]
- **sticks**[6]
- **pipes**[7]
- **coils or wires**[8]
- **pens**[9]

Other methods include ingesting dangerous substances or overdosing on medication:

- **Jik (bleach) or a bluing agent (similar to bleach)**[10]
- **concentrated tea**[11]
- **soapy water or detergent**[12]
- **malaria pills, Cytotec or misoprostol**[13]
- **herbs acquired from an herbalist**[14]

Lastly, some methods involve deliberate bodily injury, such as falling down.[15]



Some go to herbalists and they actually do terminate the pregnancy. But mostly the result is death.[16] **— Focus group participant**

The Toll of Unsafe Abortion, continued...

Unsafe abortion can result in life-long morbidities, disabilities, and death. These harms could be easily prevented— "legal abortion in industrialized nations has emerged as one of the safest procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death."[17] Complications from unsafe abortion may include incomplete evacuation of the products of conception;[18] "hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs"[19]; and vaginal or cervical lacerations.[20] Should sepsis or hemorrhaging become life-threatening, the woman may need to undergo a hysterectomy.[21] Gas gangrene and tetanus can also result from the insertion of foreign bodies into the uterus.[22] In the longer-term, unsafe abortion may result in chronic pelvic pain, tubal blockage,[23] reproductive tract infections, upper-genital tract infections, and infertility, and may increase the long-term risks of ectopic pregnancy, premature delivery, and spontaneous abortion in subsequent pregnancies.[24]

A study on maternal mortality in informal settlements in Nairobi, which found that unsafe abortion complications were the leading cause of maternal mortality, determined that "all abortion related deaths followed an abortion carried [out] by a non-professional."[25] It is important to emphasize that these deaths are caused by unsafe abortion—if performed by a competent health professional in the appropriate setting, abortion is a safe medical procedure.[26]

An obstetrician-gynecologist consultant at New Nyanza Provincial Hospital discussed the health effects of unsafe abortion that he observed in the wards: "The kind of clients we see, most of them have complications—have sepsis. They get services from quacks. We get patients with perforations. In the last month we had two clients with perforated uteruses—one had severe sepsis in the brain and is still in Ward 7, with brain damage."[27] Another obstetrician-gynecologist consultant at New Nyanza Provincial Hospital in Kisumu, further commented, "Recently, we had a student in Form 4 [secondary school] who went for a quack abortion, got infected, and went into septic shock. The infection spread to her brain and now she is a vegetable. Eight weeks later and she is still there at the Provincial Hospital, right now, and she can't talk."[28] A nurse with a private clinic in Mbita explained, "Because abortion is not legalized, women cannot afford the cost people demand from them so they resort to bush abortion, which results in sepsis because they are not using sterile equipment. So [women] die out of severe infection in their uterus."[29]

HIGH MATERNAL MORTALITY FROM UNSAFE ABORTION

- **44%** of deaths from **unsafe abortion** are in Africa.[30]
- **Unsafe abortion** is estimated to account for **13%** of all **maternal deaths worldwide**;[31] in Kenya, 35% of **maternal deaths** are attributable to unsafe abortion.[32]
- Over **2,600** women **die annually** in Kenya from complications **of unsafe abortion**.[33]
- In fact, according to a **2004 study** on unsafe abortion in Kenya, "the risk of **dying** after abortion is **alarmingly high** in Kenya, compared to global and regional estimates. The **fatality rate** associated with abortion complications was found to be higher than the rate for Africa by about **30%** [], more than two fold higher than the rate for less developed regions and the global rate [], and more than nine fold higher than the rate for more developed regions []."[34]
- A **2007 study** conducted in two informal settlements in Nairobi used a verbal autopsy tool in which fieldworkers interviewed the deceased's household members and found that more than **50%** of women who died from unsafe abortion **did not seek care** at a healthcare facility **before death**.[35]

HIGH MORBIDITY FROM COMPLICATIONS FROM UNSAFE ABORTION

- Globally, an estimated **five million** disability-adjusted life years "are lost per year by women of reproductive age as a result of **mortality and morbidity** from **unsafe abortion**."[36]
- According to one hospital-based study, approximately **21,000** women are admitted each year to Kenya's **public hospitals** for treatment of complications from **incomplete and unsafe abortion**, spontaneous or induced.[37] More than **40%** of those women "fall into the categories of probable or likely induced abortion."[38]
    - However, these statistics represent only a **fraction of the actual number** of **abortion-related complications**; they do not capture women who seek treatment at private healthcare facilities or those who cannot, or do not, obtain treatment at all.

HIGH MORBIDITY FROM COMPLICATIONS FROM UNSAFE ABORTION

- A **2005 study** found that close to **30%** of Kenyan women **hospitalized annually** with abortion complications have **complications of high severity**,[39] including uterine perforation, hemorrhage, sepsis, pelvic abscess, and shock.
- The same **2005 study** found that "**over a third** of the women admitted with abortion complications were in the **second trimester of pregnancy**," when risks of **severe complications and mortality** are substantially higher.[40]
- In a **2002 study** conducted at Provincial General Hospital in Kakamega, the referral hospital for Western Province, abortion was found to be "the most common acute gynaecological ailment with its complications accounting for the longest hospital stay in comparison with other acute gynaecological conditions."[41] **51%** of patients with **abortion complications** were **under 20** years old.[42]

A DEVASTATING IMPACT ON WOMEN AND FAMILIES

- According to a recent Lancet article, "an estimated **220,000 children** worldwide **lose their mothers** every year from **abortion-related deaths**. Such children receive less healthcare and social care than children who have two parents, and are more likely to die."[43]
- The Kenyan government's National Post Abortion Care Curriculum, in discussing maternal mortality, states, "These women leave behind **millions of motherless children** whose survival is precarious due to lack of maternal support and care. Children who are left motherless due to maternal mortality are up to ten times **more likely to die** within two years than children with two living parents."[44]

Impact on Healthcare Providers: A Case Study

Arrest and Prosecution: The Case of Dr. Nyamu and Nurses Kibathi and Mathai

The case of *Republic of Kenya v. Dr. John Nyamu and others* where three health care providers were charged with murder for allegedly performing illegal abortions is an infamous one in Kenya. Nearly all healthcare providers interviewed for this report made reference to it when discussing the challenges of providing post-abortion care and abortion services.

On May 26, 2004, 15 fetuses were found along Mombasa Road in Nairobi. On May 27, 2004, Marion Kibathi and Mercy Mathai, two nurses employed by Dr. John Nyamu, a gynecologist who runs a private clinic in Nairobi called Reproductive Health Services (RHS), were arrested. The following day, Dr. Nyamu was also taken into custody. They were alleged to have illegally performed abortions and, on the night of May 26, 2004, to have dumped the fetuses in a river near Mombasa Road, along with patient files allegedly from their clinic.[45] As Mathai remembered, "I was called from the house and told to write a statement. But I wasn't scared because we knew . . . we had not done that. . . .I was confident when I went to write the statement that I was going to go home, but never went home. I was put in a cell on 27 May 2004 and left prison on 15 June 2005."[46]

Kibathi recounted, "We were shocked. . . . The truth was I didn't know about it [the fetuses and documents being dumped on Mombasa Road]."[47] Dr. Nyamu was equally surprised by the sudden arrest and felt certain he had been set up.[48] Mathai believed their clinic was targeted "because of the higher clientele flow. It was a sabotage because of this."[49]

The clinic was searched and then shut down for a few months while inspectors looked for evidence. They found nothing to substantiate their claims. As Mathai recounted, "The hospital was closed during this time, things were auctioned. During this year there was a lot of tension . . . . This thing was politicized. When they did an investigation they realized it had nothing to do with Dr. Nyamu."[50] Dr. Nyamu further explained, "Closure was done by the MOH [Ministry of Health]. The MOH did investigations and found that there was no connection to the fetuses and our clinics so they ordered the clinic opened."[51] Another doctor stepped in to run the clinic in Nyamu's absence.[52]

The three healthcare providers were ultimately charged with two counts of murder, rather than an abortion-specific offense. Since murder is a non-bailable offense in Kenya, the three had to stay in prison until their case was decided. Dr. Nyamu was taken aback by the charges: "I didn't know that they would charge us with murder. Once they charged I knew we couldn't leave prison."[53]

Kibathi, Mathai, and Dr. Nyamu spent over a year in prison, pending their trial. According to Mathai, "prison conditions were crowded. There were two people to a mattress. Twenty-two people in one cell."[54] Kibathi,

six-and-a-half months pregnant at the time of her arrest, spent the first few nights sleeping on a cold cement floor, with "tissues for a pillow and a shawl to sleep on."[55] She became ill and experienced pregnancy-related bleeding—"the doctor said it was because I was sleeping on a cold hard floor."[56] Three weeks after their arrest, they were finally brought to the High Court, only to find that their case had been scheduled for trial in November. In the meantime, they were sent to remand, in a special section for those charged with capital offenses, while awaiting their court date.

Prison conditions were awful: it was crowded, cold, damp, unhygienic, with no privacy, and terrible food—"you get one leaf of sukuma wiki [vegetable greens] in a container. They give you the leaf in some boiled water with tasteless ugali [cornmeal porridge], uncooked," said Kibathi.[57] The prison guards harassed the prisoners, telling Kibathi, "How come you're pregnant and you've been killing other people's babies?" Kibathi barely slept and could not eat the food provided by the prison. She ended up surviving on bread and milk that she purchased from the prison shop. When first imprisoned, she shared a single mattress with another woman, despite her advanced stage of pregnancy, and was given only a small short-sleeved gown to wear despite the cold. Kibathi was repeatedly sick throughout their imprisonment and came quite close to miscarrying; she gave birth at Kenyatta National Hospital (KNH), under guard. While at KNH, some guards refused to let her eat the food her family brought to her during visits: "My mom came with tea and hot soup, the guard told my mom to pour the soup in the sink. The guard didn't like me having anything. Every time she was on shift, she would harass my guests, not give me anything to eat, wouldn't allow food from outside." Kibathi returned to prison with her newborn child where they spent the next five months together in detention. Her child nearly died from the poor prison conditions and lack of adequate nourishment, ultimately requiring hospitalization for nearly a week towards the end of their stay in remand.

When the trial finally commenced, the judge acquitted all three of the charges against them, making clear that the prosecution had no credible evidence against the accused. The judge stated that ". . . the facts of the prosecution case leaves wide yawning gaps and rents which are incapable of being filled or mended,"[58] concluding, "I find that there is no evidence against any of the three Accused persons at the close of the prosecution case."[59] The decision directly questions the veracity and motivations of the prosecution's "key witness:"[60]

> *With all humility I state that this evidence is not from a witness who just happened to witness a happening of a crime but is of a person who had some mission to achieve. His evidence in any event cannot be termed as that of an impartial or independent witness of truth and any court shall have difficulty to accept the same on its face value.*[61]

The opinion concludes by criticizing the government's handling of the case, saying "I would have expected to see a more comprehensive and professional investigation and prosecution of this case."[62]

Upon their release from prison, the three "were rearrested at the door and taken to the next court and charged again," said Kibathi.[63] This time, they were charged with the offense of killing an unborn child. However, the offense was bailable and they were spared additional prison time.[64] The charges were later withdrawn.[65]

The Chilling Impact of the *Nyamu* Case on Healthcare Providers

The consequences of the *Nyamu* case played out both on the national stage and in very personal ways. Nationally, there was a chilling effect on the provision of post-abortion care and abortion services by qualified healthcare providers. As Dr. Nyamu remembered, "The environment was bad after I was arrested. The other doctors were being harassed by the Ministry and the MPDB [Medical Practitioners and Dentists Board]."[66] Women, fearful of the media attention and threat of prosecution, declined to seek post-abortion care or abortion services from providers who were well-known and qualified—instead they went to smaller, sometimes backstreet, clinics, which they felt were more anonymous, despite the greater health risks involved.[67] Faith Mbehero of the National Nurses Association of Kenya reflected, "After Dr. Nyamu's case, the stigma around post-abortion care was much more."[68]

The impact of the case on Dr. Nyamu, Kibathi, and Mathai was particularly severe. In addition to the trauma and stress of being imprisoned and charged with murder, upon release they faced the stigma of having been tried for an abortion-related offense. Everyone in Nairobi and much of the rest of the country knew of the case. Despite having being acquitted in a case widely acknowledged to have been highly politicized and unwarranted, the healthcare community and potential clients were nonetheless wary of being tainted by association. Employment opportunities for Kibathi and Mathai were elusive; the number of patients willing to seek services at the RHS clinic dropped dramatically.

"Dr. Nyamu pleaded for us to come back [to work at the clinic]," Mathai recalled. "I didn't want to come back to work [at the clinic] because of the stigma but tried to get jobs somewhere else but because of the stigma I couldn't get [another job]."[69] After a few months, mounting bills to pay, and trauma counseling from a non-governmental organization and her church pastor, Mathai felt ready to return to RHS. Her counselors told her that "I shouldn't be scared of these things, they happen, go back to work."

Kibathi faced similar discrimination from prospective employers. She moved home to a town, a few hours away from Nairobi and when she was ready to start looking for a nursing job, she said,

> *I applied and applied and applied. I was called for interviews and every time they looked at my CV, and they see I worked for RHS with Dr. Nyamu, all the questions were about the case and how the case went. Nothing else. I did a few interviews, no one called me for a job. . . . To me, there was a lot of stigma. I thought of going back to school but I didn't have funds to go to school. . . .*[70]

Ultimately, Kibathi opened up a small store to support herself and her son.

Dr. Nyamu continued with his clinic, uncompensated for the financial losses resulting from the three-month closure after his arrest. According to Mathai, who continues to work at RHS, "After the first few months of leaving prison, we were getting few patients. I had to go around and say the clinic is open and still operating. Other providers lied to our clients and said our clinic was closed because they want our clients. One client said, 'I was told you closed and was told patients keep on dying here.' Which isn't true," said Mathai. "We never had any mortality."[71]

Dr. Nyamu, Kibathi, and Mathai have attempted to obtain redress from the government for the frivolous criminal case they were made to endure. They filed a civil suit against the government requesting compensation for the loss of income they suffered when the clinic was shut down for investigations, as well as for the medical expenses and loss of earnings experienced while imprisoned.[72] They allege that "initiating and persisting with [the] prosecution against" them was "actuated by sheer malice" and that the government's actions were "baseless and unwarranted."[73] Their civil case, filed in June 2006, has been continually delayed, most recently until 2010, by a judge citing scheduling conflicts. Meanwhile, the Attorney General's office has denied all allegations against it.[74]

Seeing the very real implications of abortion-related prosecution for financial and employment security—even with a resounding acquittal on all charges—had an undeniable, if impossible to fully document, impact on healthcare providers offering post-abortion care and abortion services. Although many providers continued to practice undeterred, many were also discouraged from continuing to provide services or were less open about advertising their services, making them less accessible to women in need.[75]

The Legal and Policy Framework for Abortion in Kenya

Kenya's Abortion Law Is Restrictive and Unclear

Sections 158–160 of the Penal Code lay out the penalties that apply to the performance of an "unlawful" abortion or "miscarriage." A pregnant woman who unlawfully procures her own miscarriage or permits another person to terminate her pregnancy is guilty of a felony and liable to imprisonment for seven years.[76] Any person who acts with the intent to unlawfully procure a miscarriage for a woman, regardless of whether she is actually pregnant, is guilty of a felony and liable to imprisonment for 14 years.[77] Doctors who perform an unlawful abortion face an additional professional penalty of suspension or erasure from the Register of Doctors as mandated by the Medical Practitioners and Dentists Board (Medical Board), the statutory body created to regulate medical and dental practice in Kenya.[78] Finally, any person who knowingly and unlawfully supplies drugs or instruments to be used in the performance of an unlawful abortion is guilty of a felony and liable to imprisonment for three years.[79]

The Penal Code distinguishes between a fetus and a newborn child, clarifying that a fetus cannot be the victim of murder under the Penal Code. Section 214 explains that "a child becomes a person capable of being killed" only "when it has completely proceeded in a living state from the body of its mother."[80] Section 214 was recently applied in a 2004 High Court case, *Republic v. Nyamu and Others*, in which the court held that supposedly aborted fetuses in question were "born dead" and therefore were not persons capable of being killed.[81]

The three Penal Code provisions on abortion mentioned above refer to the "unlawful" procurement of abortion, indicating that there are circumstances under which abortion may be lawfully provided. However, sections 158–160 do not define what might constitute a "lawful" abortion—they are simply prohibitive. Section 240 of the Penal Code can be read as creating a lawful exception: when "a surgical operation…upon an unborn child" is performed "in good faith and with reasonable care" for the "preservation of the mother's life."[82] However, the provision offers no guidance as to what circumstances may constitute the preservation of the woman's life—and there is no post-independence Kenyan High Court case law that authoritatively interprets this provision and makes clear the content of this exception.

As a result, Kenya's abortion law is unclear, leading to varied interpretations of the law and leaving many providers and members of the public unsure of its content. In an effort to understand the scope of the abortion law, some legal scholars and the Ministry of Health's own Post Abortion Care Trainer's Manual look to pre-independence legal developments for interpretative guidance.[83] Three court cases, decided between 1938 and 1959, in three distinct courts—the United Kingdom House of Lords, the East African Court of Appeal, and the Supreme Court of Kenya—shed some light on how the law has been read and understood.

In 1938, *Rex v. Bourne*, the first case that addressed the grounds upon which an abortion could legally be provided under British law, was decided.[84] At the time, British law on abortion was very

Kenya's Abortion Law and Policies

Penal Code

158. Attempt to procure abortion

Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.[85]

159. Attempt to procure abortion by the pregnant woman

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.[86]

160. Supply drugs or instruments to procure abortion

Any person who unlawfully supplies to or procures for any person any thing whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.[87]

214. When a child is deemed to be a person

A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not and whether it has an independent circulation or not, and whether the navel-string is severed or not.[88]

240. Surgical operation—the good faith clause

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.[89]

Holding in a Key Case: *Rex v. Bourne*

It is not contended that [for the purpose of preserving the life of the mother] mean merely for the purpose of saving the mother from instant death. . . . I think these words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck [then this constitutes] operating for the purpose of preserving the life of the mother.[90]

Medical Practitioners and Dentists Board's Code of Professional Conduct and Discipline

The Laws of Kenya do not allow for termination of pregnancy 'on demand' and severe penalties are meted out to those found guilty of procuring or attempting to procure an abortion or miscarriage. There is room, however, for carrying out termination when in the opinion of the attending doctors it is necessary in the interest of the health of the mother or baby. In these circumstances, it is strongly advised that the practitioner consults with at least two senior and experienced colleagues, obtains their opinion in writing and performs the operation openly in hospital if he considers himself competent to do so in the absence of a Gynaecologist. In all cases of illegal termination of pregnancies, the sentences shall be suspension or erasure.[91]

Ministry of Health, National Guidelines on the Medical Management of Rape/Sexual Violence

Termination of pregnancy as an option in case conception occurs as a result of the rape should be discussed (this is allowed in Kenya under these circumstances. It however requires psychiatric evaluation and recommendation).[92]

similar to sections 158–160 of Kenya's current Penal Code. The case was brought against a doctor who had performed an abortion on a young girl who had been raped. In *Bourne*, the House of Lords interpreted existing legislation to mean that one could "lawfully" procure a miscarriage if done "in good faith for the purpose only of preserving the life of the mother."[93] The court held that "if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck," then this constitutes acting in preservation of the life of the woman and is lawful.[94] In essence, *Bourne* created a mental and physical health exception to the criminalization of abortion in the United Kingdom.

This case has had a profound and lasting impact on the legal regimes of former British colonies. Most colonies, Kenya included, had an abortion provision essentially identical to the one at issue in *Rex v. Bourne* in their penal codes and, under common law principles, could look to British case law as an authoritative interpretation of that law.[95] The East African Court of Appeal did so in 1959, affirming the *Bourne* decision in *Mehar Singh Bansel v. R*, an abortion case on appeal from the Supreme Court of Kenya.[96] In that case, the Supreme Court of Kenya found that a lawful abortion is one that is performed for "a good medical reason," which the court interpreted to be "for the purpose of saving the patient's life or preventing severe prejudice to her health."[97] The East African Court of Appeal affirmed the Kenyan court's conclusion.[98]

Since the country's independence in 1963, the Kenyan High Court has not addressed the applicability of *Bourne* or further interpreted or defined the content of the "preservation of the mother's life" provision in the Penal Code. However, as Kenya has retained its colonial law on abortion, a persuasive argument could be made for its continuing validity as binding precedent. In 1977, the Attorney General of Kenya, in response to a letter from the Commonwealth Secretariat's Legal Division concerning the applicability of *Bourne* in Kenya, replied, "Though it has not been specifically tested in the Courts, so far as I am aware, it is probable that the extended definition of 'unlawful' given in Bourne's case would now apply in Kenya."[99] He further stated, in response to a questionnaire given to all Commonwealth member states to determine the current law on abortion in their country, that legal grounds for abortion in Kenya included preservation of the woman's life and her physical and mental health and cases of rape or incest, depending on the effect of the crime on the woman.[100]

This understanding of the Penal Code's life exception as including a mental and physical health exception is also reflected in the Medical Board's interpretation of the abortion law in its Code of Professional Conduct and Discipline (Code of Conduct), which states that "there is room . . . for carrying out termination when in the opinion of the attending doctors it is necessary in the interest of the health of the mother or baby."[101] In addition, the Ministry of Health's 2004 National Guidelines on the Medical Management of Rape/Sexual Violence (Sexual Violence Guidelines), state that "[termination of pregnancy as an option in case conception occurs as a result of the rape should be discussed (this is allowed in Kenya under these circumstances. It however requires psychiatric evaluation and recommendation)."[102] The guidelines indicate that being forced to carry to term a pregnancy resulting from rape is understood as a potential threat to a woman's mental health and therefore legal grounds for procuring an abortion.

Lack of Familiarity with and Implementation of the National Guidelines on the Medical Management of Rape/Sexual Violence

Nurses, clinical officers, and doctors are generally not familiar with the abortion language in the Ministry of Health's Sexual Violence Guidelines. Training on these guidelines, both in training schools and in-service or on-the-job workshops, has been extremely limited.[103] Where training has occurred, the component on abortion is frequently omitted. According to one Kenyan expert on reproductive health education for medical professionals, "it's hidden."[104] Healthcare providers interviewed for this report were generally unaware of the fact that the Sexual Violence Guidelines permitted the termination of pregnancies resulting from rape.

Providers who were aware of the guidelines, but untrained on the abortion component, felt that permitting abortion for rape was procedurally difficult and impossible to implement with any certainty. They explained that women, if raped, should come to a healthcare facility within 72 hours to get emergency contraception (EC). Women who come in any later are seen as suspect. A clinical officer at Kisumu East District Hospital explained his reasoning, "How do you believe them if they are coming two weeks later? We would treat you as someone who is trying to terminate pregnancy by a lie."[105] A nurse manager at Suba District Hospital concurred: "We expect if you've been raped you will come within 72 hours and get EC. We would not like to think you would come two weeks later."[106] Similarly, a nurse on the gynecology ward at New Nyanza Provincial Hospital, when asked whether she advises her patients that termination is allowed in cases of rape, stated the following:

> *We don't tell them that. These [Sexual Violence Guidelines] are just guidelines from Nairobi. People are trained on these guidelines but no one says this [termination] is an option. We don't advocate that. Someone may come and cheat you that they are raped. People will want termination and so we don't tell them.*[107]

As Monica Oguttu, executive director of Kisumu Medical and Educational Trust, has concluded in the course of her educational work on abortion with providers, "Most [providers] don't know what the policy [Sexual Violence Guidelines] says—we realize that some of the providers are barriers to services."[108]

Although a number of legal authorities and professional and government-issued guidelines interpret Kenya's abortion law to permit abortion to preserve a woman's life and health and in cases of rape, the law remains unclear, with varied interpretations abounding. Many people, including healthcare providers, believe abortion to be entirely illegal. Some providers prefer not to become entangled in an opaque interpretative web and potentially risk criminal liability and choose the safer option of viewing the procedure as prohibited. Others may interpret the law based on the guidance they are aware of, such as the Medical Board's Code of Conduct provision or the Ministry of Health's Sexual Violence Guidelines, resulting in a piecemeal approach to, and understanding of, the law. Still other providers may not know about the legal history, the Medical Board provision, or the Sexual Violence Guidelines, and understand the law solely in light of the Penal Code provisions and their personal understanding of what constitutes the preservation of a woman's life.

Unfortunately, the Attorney General has not elaborated what will and will not be prosecuted under Kenya's abortion law. Similarly, the Ministry of Health has not issued technical guidance for healthcare providers on the provision of safe abortion. Clinical guidelines play a critical role in ensuring quality and consistency of care for patients by relying on evidence-based medicine to improve the quality of clinical decisions.[109] In particular, "they offer explicit recommendations for clinicians who are uncertain about how to proceed . . . and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies."[110] The lack of legal clarification and safe abortion guidelines is a significant obstacle to ensuring the provision of safe abortion services when permitted under the law. This confusion is reflected in the teaching and training on the law that providers receive—and is further exacerbated by the problematic content of the Medical Board provision in particular.

The Medical Board's Code of Professional Conduct and Discipline: Termination of Pregnancy Provision

The Medical Board's Interpretation of the Abortion Law

The Medical Board, the statutory body charged with regulating medical and dental practice in Kenya, has issued an interpretation of the law in its Code of Conduct. [See Kenya's Abortion Law and Policies, p. 32]. Although not legally binding, the Code of Conduct regulates the medical profession and is evidence of accepted medical practice. This interpretation makes explicit a health exception to the abortion law. According to the Medical Board's chairman and its chief executive officer, health is understood to encompass both mental and physical health.[111] Further, both officials expressed the opinion that rape should fall under the mental health exception as grounds for termination.[112]

In addition, under the Code of Conduct, although consultation and performance in a hospital are "strongly advised," they are not required. As the Medical Board's chairman explained, "The Board would like an approved health facility—it could be a nursing home—and of course a qualified provider [to perform the termination]."[113] Finally, it is important to note that the practitioner performing the operation need not be a gynecologist.[114] However, the practitioner must be a qualified medical doctor, as the Medical Board's authority to regulate and discipline pertains exclusively to the medical and dental profession.[115] Thus, the Medical Board's interpretation of the law is limited in its coverage.[116] No other types of providers—such as nurses, clinical officers, or community health workers—have an interpretation of the law that applies to them in their professional capacity.

Limitations and Weaknesses of the Medical Board's Interpretation

The Code of Conduct's clarification of the law and explicit articulation of the health exception within the Penal Code's "preservation of the mother's life" language is the only guidance for medical practitioners regarding the performance of their duties within the confines of the abortion law. The provision also provides a degree of protection to registered medical practitioners who offer termination services by setting out the circumstances under which providers will not have their licenses suspended or revoked for providing abortion services.

However, sections of the Code of Conduct's abortion provision are also unnecessarily restrictive and ambiguous, creating barriers to women's access to safe and legal abortion. For example, medical practitioners are "strongly advised" to consult with "at least two senior and experienced colleagues" and to obtain "their opinions in writing."[117]

Yet this requirement is deeply impractical. As of 2004, there were 5,016 doctors in Kenya, serving a population of more than 32 million people[118] and a ratio of 16 doctors per 100,000 people[119] (Kenya's current population is estimated to be more than 39 million).[120] In many rural areas, there are no doctors in the local public health facility or hospital, and the community's health needs are taken care of by clinical officers and nurses, with assistance from community health workers.[121] In larger district hospitals in rural areas, there may be a single doctor on duty but there are rarely three doctors on duty simultaneously. To "strongly advise" that the attending doctor consult with two senior practitioners does not take into account the dearth of doctors in the country and can pose an insurmountable obstacle for doctors who wish to abide by the Code of Conduct. As an obstetrician-gynecologist from New Nyanza Provincial Hospital, the largest hospital in the province, acknowledged regarding the consultation requirement, "sometimes it's impossible to comply with, so we use our own judgment."[122]

Recommending consultation with "senior" practitioners also fails to consider the present-day reliance upon and capabilities of clinical officers to fill the current gaps in healthcare service provision in rural or underserved areas.[123] Similarly, to advise that the practitioner perform "the operation openly in hospital" is an outdated and burdensome restriction that fails to take into account new technologies in abortion provision, such as medical—as opposed to surgical—abortion. [See Clinical Methods Used for Abortion and Post-Abortion Care, p. 99].

Finally, permitting a doctor to perform the operation "if he considers himself competent to do so in the absence of a Gyneacologist" suggests an underlying preference for a gynecologist to perform the procedure and may deter general practitioners or other specialists from conducting terminations. Given that the primary concern, as articulated by the Medical Board's chairman,[124] is to have a skilled and competent healthcare provider perform the procedure, specifying that a qualified practitioner perform the operation would be sufficient. Referring to gynecologists without clearly stating that other qualified doctors are permitted to terminate pregnancies creates unnecessary ambiguity which could pose an additional barrier to effective service provision. Further, limiting the procedure to doctors,[125] without accounting for the possibility that other cadres of healthcare providers, such as clinical officers could also be "qualified provider[s]," is another obstacle to safe abortion access. As other providers are trained and permitted to perform other obstetrical and gynecological surgical procedures, such as caesarean sections or sterilization, as well as post-abortion care, there is no technical reason why they cannot also offer safe abortion services.[126]

Lack of Clarity Regarding the Content of the Medical Board's Interpretation

Interviews conducted for this report revealed that many healthcare providers, particularly nurses and clinical officers, are unaware of the existence and content of the Medical Board's interpretation of the Penal Code provision on abortion. Further, those with some knowledge of the Medical Board's interpretation were often misinformed about its content, citing procedural requirements that are neither found in the Penal Code nor stated in the Medical Board's interpretation. This may be due to the fact that, according to Dr. Margaret Meme, gender and reproductive rights program manager, and Dr. Annie Gituto, maternal newborn health program officer, at the Ministry of Health's Division of Reproductive Health, practitioners "have not been taught the steps [of legal termination] in school—they learn from friends."[127]

For example, although the Medical Board's interpretation states that consultation with two senior colleagues is "strongly advised," in practice this is often understood to be an absolute requirement. Although the Medical Board refers only to consultation with "two senior and experienced colleagues," many believe that such approval must be sought from a gynecologist and psychiatrist in particular.[128] A study carried out in Nairobi by a Kenyan gynecologist found that all the recorded therapeutic abortion cases he identified had been performed only after obtaining a written recommendation from a psychiatrist.[129] This misinformation can be traced to training schools' curricula: one of Kenya's two medical schools teaches students to seek the written opinion of two medical practitioners, "usually a psychiatrist and another doctor"[130] while the nursing school at the University of Nairobi teaches nurses to first find a gynecologist and psychiatrist if a termination is to be considered.[131]

The Medical Board's Code of Conduct does not in fact contain a gynecologist or psychiatrist consultation requirement. As discussed in the previous section, the actual Medical Board recommendation of consulting two senior practitioners is already quite burdensome—finding a psychiatrist to consult with may be entirely impracticable for most practitioners. As of November 2009, there were 62 psychiatrists registered to practice in Kenya,[132] with the majority likely to be located in Nairobi.[133]

Lack of Clarity on Legal Status of Abortion in Teaching and Training of Providers

The confusion surrounding the interpretation and understanding of Kenya's abortion law is reflected in the teaching and training on the law that healthcare providers receive. The lack of clarity on the legal status of abortion, combined with the stigma and perceived illegality surrounding the procedure, often translates into a vague and conservative approach to teaching the law. This approach, in turn, perpetuates the lack of clarity surrounding the legal status of abortion in Kenya.

This confusion is apparent in the government's own Post-Abortion Care Trainer's Manual, which is designed to be used for both pre-service and in-service training of nurses, clinical officers, and doctors.[134] The manual states that the law "permits abortion only for the preservation of the woman's life" and then, on the same page, states that "[i]n Kenya, induced abortion is illegal."[135] The manual refers to the life exception as a "loophole" used by people "to procure abortion on the pretext that the woman's life is in danger."[136] In a later effort to explain the life exception, the manual acknowledges that "[i]t is difficult to define what this means in different situations."[137] It then offers limited and ambiguous guidance: "When a pregnant woman's life is in danger because of the pregnancy, it therefore requires legitimizing abortion; in other cases the woman may not be in danger."[138]

In professional schools, which often have their own curricula, the training on Kenya's abortion law is also unclear and inconsistent. For nurses and clinical officers, the law is either not covered in their curriculum or is covered in a very limited or superficial manner, with a strong focus on the prohibitive nature of the law. The educational focus is on the perceived illegality of the procedure and on discouraging these providers from offering such services. Doctors are taught most comprehensively about the law; however, even then, it appears that the content of what is taught depends on the professor's particular interpretation of the law, leading to varying understandings of the law among students.

Nurses Lack Legal Protection for Performing Abortions and Clarity on the Law

According to most of the nurses interviewed for this report, the abortion law is not covered in their training. The belief among a number of those interviewed is that abortion is illegal, with no exception to preserve the woman's life or health.[139] As one nurse explained, "We need more information on the law. We only learn about the care afterwards. We don't have enough information to advise her on what should be done, so she'll end up doing it in secret. . . . [W]e only know what we hear when we read the papers."[140] Education officers David Wambuku and Frederick Ochieno from the Nursing Council of Kenya, a body charged by law to "prescribe and regulate syllabuses of instruction and courses of training for [nurses],"[141] confirmed that "the law on abortion is not taught to nurses in the curriculum. . . . If we wanted it to be taught, we would have it in our syllabus."[142]

Wambuku and Ochieno attribute this omission to the fact that termination is not within the nurses' official scope of practice and does not need to be extensively taught. They provided a similar explanation for why the Nursing Council has not issued an interpretation of the abortion law for nurses, as the Medical Board has done for doctors, explaining that nurses "don't need an interpretation of the abortion law" because "nurses are not supposed to terminate a pregnancy."[143] Instead, they said, nurses are taught simply not to participate in the procurement of an abortion.[144] To reinforce this understanding, the Nursing Council's Code of Ethics and Professional Conduct for Nurses, under a non-exhaustive catalog of disciplinary offenses, lists "performing or assisting in illegal procedures e.g. procuring abortions" as a malpractice offense.[145] The code mentions no exceptions wherein procuring an abortion may be considered legal.[146]

Lecturers at the Department of Nursing at Kenyatta National Hospital assert that they do teach about the abortion law. One lecturer explained, "The law says unless the mother's life is in danger that is the only time you can procure an abortion but otherwise it is illegal," while another lecturer summarized the law as follows: "Abortion is illegal but only allowed to be performed on medical grounds."[147]

Clinical Officers Lack Training and Information on Abortion Legal Standards and Practice

Clinical officers are mid-level healthcare providers "who offer a wide range of medical services" and "supplement the work of medical doctors at all levels of healthcare. . . ."[148] According to the Clinical Officers Council, which is charged with overseeing clinical officers' training,[149] clinical officers are taught the content of the abortion law.[150] However, as with nurses, the educational focus appears to be primarily on the prohibitive nature of the Penal Code provisions. The registrar at the Council, who is also the chief clinical officer at the Ministry of Medical Services, explained that clinical officers "talk about the law on abortion when covering medical-legal issues; abortion is illegal in the country," while the deputy chief clinical officer at the Ministry of Medical Services clarified that clinical officer trainers "say it is illegal but there are some exceptions . . . when the life of the mother is in danger."[151] Both the chief and

deputy chief clinical officers, after explaining the illegality of the procedure, emphasized that the role of a clinical officer is simply to refer abortion cases to medical practitioners—"it's better to refer because we don't want [clinical officers] to get in trouble."[152] Therefore, they explained, an official interpretation of the abortion law by the Clinical Officers Council—similar to the Medical Board's Code of Conduct provision—was unnecessary for clinical officers because "they would never do a termination."[153]

A clinical officer interviewed for this report corroborated this somewhat vague training content: "We don't talk much about the law. We say it's illegal but in some cases it's allowed, to save the woman's life."[154] Although the life exception is mentioned in training, there does not appear to be much discussion regarding the practical application of the exception to their clinical practice—perhaps, in part, because the Clinical Officers Council believes the procedure to be outside the scope of clinical officers' practice.[155]

The result is that confusion persists on the scope and meaning of the exception. Without the tools to analyze and understand the life exception, clinical officers are left to conclude that the provision is too vague to protect them or only applies to the most extreme and indisputable—and therefore rarest—of circumstances. For example, "[p]eople understand 'save the woman's life' to be if the woman will die in the next five minutes," observed a manual vacuum aspiration (MVA) trainer for clinical officers and nurses.[156] Or as one clinical officer from Kisumu remarked, "There are no exceptions. There is no legal abortion—except if terminating to save the mother's life. But how do you ascertain if the mother is at risk? How do you prove a woman is at risk if you're taken to court?"[157]

Doctors Remain Unclear about Legal Standards for Abortion Access

Confusion about what is permitted under the abortion law persists among doctors as well. "We didn't talk about the law in university. At university we were taught about post-abortion care but not about termination," a general practitioner trained at Moi University stated.[158] Similarly, a gynecologist trained at the University of Nairobi explained that they were never taught the law in medical school.[159] This fact may explain the incorrect belief of pediatrician and chief administrator at New Nyanza Provincial Hospital, as told to the Center for Reproductive Rights, that "there is no legal termination."[160]

This gap has recently been addressed by the 2007 comprehensive revision of the obstetrics and gynecology (OB/GYN) curriculum at the University of Nairobi[161] and the law's inclusion in the past decade in the OB/GYN curriculum at Moi University,[162] the two existing medical schools in Kenya. However, the degree to which the law is taught to medical students still varies by professor. Where one professor may say explicitly that abortion is an option in cases of rape, another may not mention when abortion can be legally performed and simply state that it may be done to preserve the life of the mother.[163] Thus, students' understanding of the law ranges widely—shaping their practices and approaches to abortion provision following graduation. However, of all the cadres of healthcare providers, doctors had the greatest familiarity with the content of the law, perhaps due to the presence of the termination of pregnancy provision in the Medical Board's Code of Conduct.

Post-Abortion Care: Regulatory Framework Affirms Importance of Providing Services

> *Every woman in Kenya shall have access to high quality comprehensive PAC [post-abortion care] as a component of integrated [reproductive health] services.*[164]
>
> ***— Goal Statement issued by the Ministry of Health, Kenya, May 2000***

The Ministry of Health has made clear that "emergency care for complications of abortion (postabortion care), both spontaneous and induced, is legal and not punishable by any part of Kenya laws."[165] According to its National Post Abortion Care Curriculum,

> *[c]omprehensive [post-abortion care] is a life saving procedure that should be available to all women and provision of comprehensive postabortion care does not lead to punishment or withdrawal of registration of the service provider. The medical profession has the responsibility to provide comprehensive postabortion services including family planning to all women who need them.*[166]

Critically, however, the curriculum does not address whether a woman seeking post-abortion care is protected from punishment or arrest.

The provision of post-abortion care in Kenya is regulated by a number of policy documents issued by the Ministry of Health. These strategic plans, standards, and guidelines address service provision, the training of reproductive health service providers, and the minimum standards of care required for effective post-abortion care. In essence, they detail where post-abortion care services must be offered, who is responsible for providing them, and what those services should entail. Notably, there are no guidelines on fee structures for post-abortion care or fee exemptions or waivers for these services. There is a section containing technical guidelines on the management of complications of abortion within the Ministry of Health's Essential Obstetric Care Manual;[167] however, it is unclear the extent to which providers are aware of these guidelines. The Ministry has not published any technical guidelines focused exclusively on the provision of post-abortion care.

In 2006, the Ministry of Health issued the Second National Health Sector Strategic Plan for Kenya: Norms and Standards for Health Service Delivery, defining the essential services that must be made available at each level of healthcare facility in Kenya.[168] Under this plan, post-abortion care is considered an essential service and must be provided at five of Kenya's six levels of healthcare facilities, with only community healthcare systems charged solely with health promotion and referral not required to offer post-abortion care. Specifically, level-two facilities—dispensaries and clinics[169]—must make available a registered comprehensive nurse who can provide post-abortion care.[170] At level-three through level-six facilities, which encompasses health centers, maternities and primary, secondary and tertiary hospitals,[171] a clinical officer or a medical officer must be available for post-abortion care.[172] The strategic plan specifies that MVA is to be used for incomplete abortions.[173]

The Ministry of Health's Adolescent Reproductive Health and Development Policy Plan of Action also addresses post-abortion care.[174] As part of the Ministry of Health's goal to provide quality and sustainable youth-friendly reproductive health development services, the plan of action outlines essential adolescent reproductive health commodities and services and includes post-abortion care on this list.[175]

The 2007 National Reproductive Health Policy, which aims to "enhance the reproductive health status of all Kenyans by: increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to client needs," does not explicitly address the provision of post-abortion care.[176] However, it does encourage "increas[ed] access to both comprehensive and basic emergency obstetric care" as a priority action to reduce maternal morbidity and mortality in Kenya.[177] As discussed below, basic emergency obstetric care is understood to include the MVA procedure—a critical component of post-abortion care.

In practice, as this report documents, these laudable policies remain largely unfulfilled, as the availability of post-abortion care is threatened by stigma, a lack of funding and supplies, and a dearth of trained and willing providers.

Training Standards Reinforce Need for Post-Abortion Care

The same year that the Ministry of Health issued its Norms and Standards for Health Service Delivery, it also released a National Reproductive Health Curriculum for Service Providers.[178] The curriculum was "born out of the need to harmonize and standardize the various curricula used in reproductive health pre-service and in-service training" and "forms the minimum package necessary for training in comprehensive reproductive health."[179] The national curriculum applies to doctors, nurses, and clinical officers alike.[180] A curriculum unit is devoted to post-abortion care and requires a learner to "describe MVA facts, procedure and emergency treatment for a post-abortion client[,] [m]anage complications of abortion and pain during MVA procedure," and "[p]rovide post-abortion [family planning] counseling and services."[181] All reproductive health service providers in Kenya should have this set of skills and are responsible for providing these services.

Standards of Care from Ministry of Health Clarify Need for Post-Abortion Care

The Ministry of Health has also defined basic essential obstetric care and basic post-abortion care services. In 2002, in collaboration with health professionals in Kenya and the United Kingdom, the Ministry developed Standards for Maternal Care in Kenya,[182] guidelines that focus on standards for obstetric emergencies.[183] In these guidelines, basic essential obstetric care is defined to include MVA[184] and elements of basic essential obstetric care are expected to be available at all levels of healthcare.[185] In addition, an MVA kit is listed as "Basic Essential Obstetric Care Equipment."[186] Comprehensive essential obstetric care is "generally only available at hospitals"[187] and further includes a dilation and curretage (D&C) set in the list of equipment.[188]

These guidelines discuss the management of complications of unsafe abortion and outline three basic standards that must be met in the provision of post-abortion care services; these standards are based on best practices, as determined by the available scientific evidence and expert opinion both locally and generally.[189] First, every woman who suffers from an incomplete abortion should undergo evacuation, MVA, or D&C within 24 hours of diagnosis.[190] According to the guidelines, this requires a room to be set aside for evacuation and minor surgery as well as guidelines and protocols for the management of incomplete abortions.[191] The clinical guidelines/protocols must be displayed, the client must be examined and diagnosed, and the uterus must be evacuated using MVA or D&C as per protocol.[192] Afterwards, the client must be given antibiotics and allowed to rest.[193] The goal is to reduce the incidence of case complications, delay in case management, and the fatality rate.[194]

Human Rights Violations Leading to Unwanted Pregnancies

According to the 2003 Kenya Demographic and Health Survey (2003 KDHS), "nearly 20 percent of births in Kenya are unwanted and [an additional] 25 percent are mistimed (wanted later)."[201] High rates of sexual violence, limited access to family planning services and information, poverty, and discrimination against pregnant adolescents are key factors leading to unwanted and unplanned pregnancies and, consequently, unsafe abortion in Kenya.

The Prevalence of Sexual Violence Contributes to Unwanted Pregnancies

Although sexual violence is widely underreported, making it difficult to gather accurate statistics on its prevalence, existing figures indicate that sexual violence is a serious and pervasive phenomenon in Kenya. In a 2003 survey of 1,652 Kenyan women between the ages of 17 and 77, 52% reported being sexually abused in their lifetime while over 30% reported an experience of forced sexual intercourse in their lifetime.[202] In 2009, the organization Men for Gender Equality Now compiled data on rape in Kenya from a number of sources, including police records, and found that 16,400 rape cases are reported annually.[203] It further found that police reports indicate that "sexual assault cases constitute 50 per cent of offences reported to the force."[204]

Sexual violence occurs in marital or intimate partner relationships as well as outside of them. According to the 2003 KDHS, "[m]arital rape appears to be common, with 15 percent of married women and separated or divorced women reporting having experienced forced sexual intercourse; 12 percent report this experience in the 12 months preceding the survey."[205] 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%.[206] The data also indicated a statistically significant relationship between intimate partner violence and unintended pregnancies.[207] Further, the study showed that, in Kenya, a slightly higher percentage of abortions are procured by women who have experienced intimate partner violence than by those who have not.[208]

Sexual violence is also pervasive in schools. A recent study by the Centre for the Study of Adolescence found that at least one in twenty boys in high school reported coercing girls into sex; the same number of boys reported having made a girl pregnant.[209] Sexual abuse perpetrated by teachers against female students is also not uncommon in Kenyan schools.[210] A 2009 report by the 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. These numbers may be underestimates given the report's finding that "90 per cent of sexual abuses cases never reached the TSC."[211] According to press reports, the limited reporting and accountability for these abuses stems from the intimidation of survivors of sexual violence by education officials and offenders, the stigma surrounding sexual abuse, and the practice of paying the student's parents monetary compensation and of "offenders offer[ing] to marry the girls."[212] Sexual violence in Kenyan schools contributes to the high rates of teenage pregnancy in Kenya. [See Discrimination against Pregnant Girls in Kenyan Schools, p. 53].

Sexual violence, in the form of rape and gang rape, was a significant component of Kenya's post-election violence in 2007–08. The Commission of Inquiry into Post-election Violence, also known as the Waki Commission, dedicated an entire chapter of its final report to sexual violence, documenting testimonial evidence from both survivors and medical professionals relating to the marked increase in sexual offenses during the post-election violence. Witnesses testifying before the Commission reported "unwanted pregnancies, including the cases of two 14 and 16 year old girls who had been raped after which they found themselves doubly burdened." [213] Dr. Sam Thenya, chief executive officer of the Nairobi Women's Hospital, which provides free services to sexual violence victims, "told the Commission that his hospital was inundated with patients during the post election period."[214] These patients were primarily women and girls who had been raped or defiled.[215] According to Dr. Thenya, many of these women were unable to receive the "comprehensive services" normally offered to survivors of sexual violence because they came to the hospital more than 72 hours after the incident, due to the lack of security and transportation during the post-election period.[216] Such comprehensive services for survivors of sexual violence should include emergency contraception (EC), according to the Ministry of Health's National Guidelines on the Medical Management of Rape/Sexual Violence (Sexual Violence Guidelines).[217]

Newspaper reports confirm the Waki Commission's findings: workers at Nairobi Women's Hospital interviewed by the BBC and IRIN news recounted witnessing nearly double the average number of rape cases per day during the post-election violence.[218] These workers also noted that the rise in hospital visits was likely just "the tip of the iceberg," because many rape victims were unable or unwilling to go for treatment.[219] The Commission report similarly acknowledged that 82% of victims likely did not report the violence they suffered to Kenyan police.[220] As the Women's Commission for Refugee Women and Children documented following the post-election violence,

> *[t]he consequences of unwanted pregnancies were [] beginning to be seen in camps [for internally displaced persons] at the time of the assessment [in August 2008]. Cases of women and girls suffering from unsafe abortion had been reported in camps. Nakuru Showground clinic reported that in the week preceding the interview alone, there were two patients, one a 16-year-old who had used a pen and the other a 20-year-old who had used a coat hanger. The two women had come to the clinic for infection treatment.*[221]

Lack of Access to Emergency Contraception (EC) and Abortion in Cases of Rape

Victims of sexual violence in Kenya have limited recourse at their disposal to prevent or end unwanted pregnancies. Although the Ministry of Health's Sexual Violence Guidelines state that "[i]n view of the psychological consequences of conceiving after being raped, every non-pregnant woman/girl of childbearing age not covered by a reliable form of contraception, should be offered emergency contraception,"[222] many women who have survived sexual violence never receive EC. The reasons for this are varied. For some women, a lack of transportation prevents them from seeking medical attention; for others, the stigma associated with sexual violence and rape deters them from obtaining healthcare. For example, the Waki Commission report notes that many victims of the post-election violence did not report being raped or seek medical attention out of fear of being beaten or abandoned by their husbands.[223] Still others were unable to safely travel to the nearest health facility within the window of time during which EC is effective in preventing pregnancy.

Even when women can access a health facility, they face barriers to EC access. Private healthcare facilities may not always offer EC services. Catholic facilities and those under the Christian Health Association of Kenya do not provide EC, although some of these facilities treat victims of sexual violence.[224] Further, ensuring an adequate and consistent supply of EC has been a challenge for public health facilities and EC may not always be in stock when rape victims seek care. [See Access to Emergency Contraception is Limited, p. 47]. In addition, healthcare providers at government facilities may express suspicion as to why a woman needs EC.[225]

Finally, healthcare providers trained on how to care for survivors of rape and sexual violence through use of the Ministry of Health's Sexual Violence Guidelines may unwittingly present a barrier to access. The Sexual Violence Guidelines state that EC can be given up to 72 hours after rape.[226] This is inconsistent with the World Health Organization's recommendations[227] and the Ministry's own guidelines on EC, which state that EC should be used "as soon as possible, but within 120 hours of unprotected sex."[228] Women may be denied EC during the further two-day window when it still may be effective because the Sexual Violence Guidelines have not been updated to reflect contemporary medical practice. Many of the healthcare providers interviewed for this report asserted that EC had to be administered within 72 hours.[229]

The Sexual Violence Guidelines additionally state that pregnancy termination should be discussed as an option with sexual violence survivors in case conception occurs as a result of the rape, explaining, "this is allowed in Kenya under these circumstances."[230] However, interviews conducted for this report revealed that nurses, clinical officers and doctors shared a profound lack of awareness about the abortion language in the Sexual Violence Guidelines. [See Lack of Familiarity with and Implementation of the National Guidelines on the Medical Management of Rape/Sexual Violence, p. 34]. Mission hospitals do not provide or discuss terminations despite treating and counseling victims of sexual violence. According to a nurse who once worked at a mission hospital, "They said that abortion is illegal. Period. It's evil, ungodly."[231]

Lack of Access to Contraceptives

Access to contraceptives in Kenya is limited by the government's failure to ensure an adequate and consistent supply of contraceptives, financial barriers to contraceptive access, and discriminatory service provision stemming from the stigma surrounding women's and girls' sexuality in Kenya. According to the 2009 KDHS Preliminary Report, the modern contraceptive prevalence rate for married women is 39%.[232] The 2003 KDHS also found that 25% of married women in Kenya have an unmet need for family planning; the unmet need is even higher than 25% for women aged 15–24 and 30–34.[233] The lack of meaningful access to a comprehensive range of contraceptive methods puts women and girls at a greater risk of unintended pregnancy.

Kenya's public health facilities have consistently suffered from severe shortages, or "stock-outs," of contraceptives in recent years.[234] The 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) found that "[a]bout one in five facilities (19 percent) providing combined oral contraceptives and 18 percent of facilities providing progestin only injectables reported a stockout some time in the 6 months before the survey. Stockouts were much more common with implants (75 percent), intra-uterine devices (37 percent), and emergency contraceptives (69 percent). For the most popular methods, oral contraceptives and progestin-only injectables, stockouts were more common among

NGO and [faith-based] facilities than among private and government facilities."[235] Supplies of EC, a popular form of contraception in Kenya, are particularly low in government stores. [See Access to Emergency Contraception is Limited, p. 47].

The government, through the Kenya Medical Supplies Agency (KEMSA), is the main provider of contraceptives in Kenya.[236] According to press reports, "Josephine Kibaru, head of the Family Health Department within the Ministry of Health, [has said] the stock-outs have been largely due to insufficient funds to purchase the commodities."[237] In addition, the government's budget for procurement of family planning commodities is currently at least thirteen million dollars short of what is required "to ensure adequate supply."[238] Bureaucratic obstacles, such as significant difficulties and delays in securing the release of funds from the treasury, have also been criticized for hindering contraceptives procurement.[239]

In addition, some have blamed KEMSA "for failing to deliver promptly contraceptives to government facilities."[240] According to one news source, KEMSA's poor distribution record is due, in part, to a lack of adequate funding for distribution. Contraceptive donations are not covered by KEMSA's distribution budget, resulting in "huge quantities of drugs [remaining] in the [KEMSA] stores even as public dispensaries, health centres and hospitals countryside report serious shortages."[241] In May 2008, 900 million condoms lay unused in government stores due to insufficient funds for distribution.[242] Nongovernmental organizations have been unable to fill the contraceptive supply gap because of their "limited fund resource base[s]."[243]

In addition to supply shortages, Kenyans also face financial barriers to obtaining contraceptives. Despite the Ministry of Health's policy that contraceptives should be available free of charge, the 2004 KSPAS found that 42% of government facilities charged user fees for family planning services and 8% of government facilities charged for the contraceptive method itself.[244] The private sector poses similar financial obstacles to contraceptives access. Although private drug stores do have contraceptives consistently in stock, their prices are often too expensive for most Kenyans.[245]

A 2009 Inter Press Service news article quoted Karen Owuor, a public-sector nursing officer in Nyanza Province, who explained: "Majority of our clients prefer injectable or surgical contraceptives but these are not accessible in most of our facilities. Even though they are available in the market, not many people can afford them so they either have to wait until they are supplied to the hospitals or get pregnant."[246] As a result, reported *The Standard*, "[p]oor women who cannot afford contraceptives are turning to uncertified herbal medicines," which pose life-threatening side effects and are of questionable effectiveness.[247] According to the current Minister of Medical Services Anyang' Nyong'o, unintended pregnancies from poor access to contraceptives have driven up the rate of illegal abortions.[248]

Adolescent Access to Contraceptives is Impaired and Stigmatized

> *In Kenya opposition from religious and community leaders as well as policy and decision makers has often been a major barrier, preventing young people from accessing information and services, which would enable them [to] meet their sexual and reproductive health needs. In addition, even where services exist, cultural attitudes about sexuality and the rights of young people create serious barriers and prevent young people from accessing these services.*[249]
>
> ***—2008 Study by the Centre for the Study of Adolescence, Kenya***

Adolescents in Kenya face additional barriers to accessing contraceptives: stigma and discrimination. A recent news article on adolescent sexual education quoted a Kenyan youth peer educator as saying, "I once visited a hospital with a reproductive health problem and instead of getting help, I received judgmental looks from the medics. Instead of quickly offering me assistance, they interrogated me about why and with whom I was having sexual intercourse. . . . I bore the shame of their questions and got the help I needed, but I would never go back there again."[250]

A focus group discussion with youth in Mombasa conducted for this report also raised the issue of the lack of youth-friendly services in Kenya. As the adolescents and young women affirmed, "Government facilities say nasty things when you go for family planning: 'Are you a prostitute? Are you married?'"[251] One young woman in the focus group told of her discouraging experience trying to access contraceptives in a public health facility: "I tried to get a coil [intra-uterine device] when I was 18 years old and they said no at the government facility. They said you are a Muslim girl, you are going to burn in hell. She was a Muslim nurse and refused to give me contraceptives."[252]

Such stigma and discrimination is particularly acute for adolescents seeking EC, also known as "e-pills," in public health facilities. Another young woman in the Mombasa focus group explained, "They will ask you lots of questions and you want to avoid this. People don't go to government [facilities] for e-pills. The nurse at the [nearby] government facility hired a youth to sit at the counter to offer services instead but still people do not come."[253] Youth focus group participants in Kibera agreed: "At times it [EC] can be free from the government but the clinic is not friendly and will see [girls] as promiscuous."[254] As a result, young people often turn to the private sector, despite the increased costs, to receive appropriate services and guaranteed access to EC. Although the government offers EC for free, young girls and women are deterred from using public facilities, leaving them with only the private sector as an option and causing the girls from Kibera to conclude that "EC is not affordable. It's expensive."[255]

Providers, too, acknowledge the lack of youth-friendly services. A reproductive healthcare provider and nurse who works at Coast Provincial General Hospital in Mombasa noted, "No one in Kenya will accept you to talk to young girls about family planning. The girls rarely come because they feel if they come they'll be scolded. So the government needs to put posters that family planning is allowed even for young girls, whether you're married or not. . . . We talk to young girls about family planning but they don't come often."[256]

Access to Emergency Contraception Is Limited

The use of EC in Kenya has increased dramatically in recent years.[257] This rise in use is attributed to an "increased supply in the private sector, greater attention in the media and improved provider comfort with the method."[258] Despite the clear public demand for EC, Kenyan public health facilities are insufficiently stocked. Although 700,000 units of Postinor-1 arrived in Kenya in March 2005, "central stores were stocked out by December 2006."[259] Since then, the Population Council has worked closely with KEMSA and the Ministry of Health to ensure that central stores are adequately stocked with EC.[260] However, maintaining consistent stocks has proven challenging.[261] By the end of June 2009, only 0.3 months' worth of EC stock remained at KEMSA stores, whereas the minimum recommended stock is 10.3 months.[262] Furthermore, due to stock-outs and delayed shipments, the number of EC stocks issued from the central storehouse to various districts in 2008 was lower than the stock issued in 2007.[263]

The supply shortage is not the only critical barrier to accessing EC. A Population Council study found that, in addition to stockouts, a primary reason for EC denial in pharmacies is the pharmacist's insistence on a doctor's prescription,[264] despite the fact that EC is an over-the-counter drug and subject to no such restriction. The chief pharmacist at Suba District Hospital, explained during an interview for this report, "We do stock EC but require a prescription mainly because there is potential for abuse. Some people are not raped and just have sex. You have to go through the clinic and have been examined for rape and then come here with a prescription."[265]

Interviews for this report further suggest that women are being denied EC by providers and pharmacists on the basis of age and marital status and personal perceptions of "abuse" of EC, although these are not valid reasons to withhold EC according to the Ministry of Health's 2008 EC guidelines for healthcare providers. The guidelines state that "EC is used after unprotected sex" and does not limit the situations in which it can be dispensed.[266] They further state that "EC can be safely used by adolescents."[267]

Nonetheless, stories of arbitrary refusals to provide EC were common amongst the women and providers interviewed for this report. Young women and adolescents from Kibera who participated in a focus group discussion stated that "for EC they [government family planning facilities] normally prefer you to be 21 years or older."[268] This was corroborated by pharmacists. A programs pharmacist at Family Health Options Kenya, explained that the "reason why [pharmacists] would hold back contraceptives is because the person looks young."[269]

Similarly, a nurse manager of Suba District Hospital said that in his facility the family planning clinic dispenses EC but they "don't just give it out. Clients have to tell you what happened and explain grounds for needing EC. If it's rape, they have to go through the clinic and PEP [post-exposure prophylaxis]…. Otherwise, they have to say this was with their husband and was unprotected and unplanned. If you give too much EC it may end up getting abused."[270] It appears that within the hospital itself, access to EC may be even more limited. When asked whether the hospital stocks EC in the pharmacy, the chief pharmacist at Suba District Hospital responded yes; however, he also noted that there is "potential for abuse" and asserted that EC is "only available for rape victims."[271]

This misinformation may stem, in part, from a lack of awareness among pharmacists about the government's EC guidelines.[272] According to Dr. Stephen Kimatu, pharmacist and head of the Medicines Information Department at the Pharmacy and Poisons Board, there are no EC guidelines for pharmacists so "it's about the personal judgment of the pharmacist. They are looking for married couples, a woman [who] wasn't using contraceptives and they are not looking to have a baby, or something that happened extraordinary in a relationship."[273] Kimatu further explained, "you need to get some history on why it's being used. You have to take a bit of history, talk to the patient and see whether that case warrants the use of [EC]."[274]

Despite the fact that EC is an over-the-counter drug and the Ministry of Health has issued clear guidelines on EC that permit its use after any unprotected sex, some healthcare providers are applying their personal beliefs about sexuality and social mores to the provision of a legal, unrestricted contraceptive method. There appears to be no oversight or regulation of providers in this area, leaving women little recourse but to face the stigma and denial and attempt to seek services elsewhere.[275] The lack of meaningful access to EC has serious implications for women's ability to prevent an unwanted pregnancy.

Lack of Access to Reproductive Health Information and Sexuality Education

Accessible and accurate information about sex and reproductive health is limited in Kenya. Poor sexual education in schools and insufficient government outreach on family planning methods are primarily to blame. With minimal, and sometimes inaccurate, information about contraceptives and family planning at their disposal, many Kenyans—adolescents, in particular—are ill equipped to prevent unwanted pregnancies.

Youth in Kenya lack basic information about sex and reproductive health. Although the 2003 KDHS found that 52.8% of women aged 20–49 and 57.4% of men aged 20–54 had sex by their 18th birthday,[276] sex education in secondary schools in Kenya is limited[277] and, in some cases, nonexistent.[278] A recent Inter Press Service article explained that "[s]ex education at Kenya's government schools is all but silent on contraception and safe sex largely due to stiff resistance from churches, led by the Catholic Church."[279] This assessment is corroborated by Dr. Shanaaz Sharif, Director of Public Health and Sanitation at the Ministry of Health, who has stated that the content of the sexual education curriculum in schools is so thin—due to opposition from parents, religious organizations, and some civil society groups—that much of the message regarding safe sex is not getting through to Kenya's youth.[280] He affirmed, "[W]e are not telling them there is an option of safe sex."[281]

Without formal and comprehensive sex education in schools, many youth receive their information—and misinformation—about pregnancy prevention from their peers.[282] Misinformation about sexuality and pregnancy prevention is widespread: one example is a 17-year-old boy from St. Georges Boys Secondary School in Kilifi, who was told that "if one has sex while standing, pregnancy will not occur."[283] This lack of accurate information has serious consequences for young girls. George Kichamu, senior assistant director at the National Coordinating Agency for Population and Development, notes that without appropriate information about safe sex and family planning, girls "find themselves falling pregnant."[284] An estimated 5.5 million Kenyan girls between the ages of 15 and 19 give birth annually.[285]

The lack of sexuality education in schools has long-term consequences for individuals' understanding of their sexual and reproductive health. If youth do not learn about family planning or contraceptives in school, they may never be properly exposed to such messages. For example, according to the 2003 KDHS, 25% of women[286] and 29% of men[287] had not been exposed to family planning messages through the media, including radio, television and newspapers/magazines, in the months preceding the survey. Further, inadequate sexuality education in schools leaves many individuals unable to distinguish between misleading and accurate media messages about contraception. For example, according to the Population Council, potential users of EC may be deterred by inaccurate media reports that contribute to public misperceptions about the health risks of EC.[288]

The lack of information and the misinformation about contraception directly affects contraceptive use and uptake among sexually active women. The 2003 KDHS found that 54.8% of women who use modern contraceptive methods were not informed about the side effects or problems of the methods used; similarly, 53.2% of women users were not informed of other methods that could be used, aside from their current method.[289] This lack of knowledge about the range of methods available impacts women's decisions about using contraception: the 2003 KDHS further found that 25.4% of women discontinued use of a method due to side effects,[290] which they may not have been aware of when they started. In addition, 13.4% of married women who are not now using contraceptives and do not intend to use a contraceptive method in the future cited fear of side effects as their primary reason.[291] Inadequate access to comprehensive information about family planning services and methods can have a considerable impact on both immediate and long-term contraceptive use.

Finally, poor government outreach and information campaigns on family planning services create further barriers to access. For example, a focus group discussion held by the Center for Reproductive Rights with young women and girls in Mombasa, many of whom believed they could not afford EC, revealed that many did not know that EC is free in government facilities.[292] Further, focus group participants from Kibera voiced the belief that family planning was exclusively for married women; as one participant stated, "we are not married so family planning is not for us."[293]

GRACE WAS TWELVE WHEN A STRANGER RAPED HER,

and left her pregnant. After having the child she was rejected by her mother and made to fend for herself, settling in Nairobi and working as a housegirl washing clothes.

> *Life became very difficult. I had no assurity of having jobs daily. So I had to have a friend to keep the daughter in school. Because of that I get pregnant. After that pregnancy I feel myself that I cannot keep the baby. . . .*

Grace's Story: Trapped by Poverty

Grace was twelve when a stranger raped her in her rural village and left her pregnant. She gave birth to a daughter at thirteen and was eventually thrown out of the house by her mother. She made her way to Nairobi and settled in an informal settlement on the city's outskirts, supporting herself and her daughter by working as a housegirl and washing clothes for others, making enough money to survive and pay her daughter's school fees. But then, explained Grace,

> *Life became very difficult. I had no assurity of having jobs daily. So I had to have a friend to keep the daughter in school. Because of that I get pregnant. After that pregnancy I feel myself that I cannot keep the baby. . . . The friend cannot keep me in the house. He told me that he has a wife last year. I asked how can I become a mother of two when I have no job and nothing to do? I decided to [have an abortion] because of the child I already have. . . . Abortion is not good but because of the situation there is not anything else we can do. I tried but there was nowhere where I could go for help, it is only me and my daughter.*[294]

Grace ended up procuring an unsafe abortion. She explained, "I had no money to go to the hospital. So I decided to go to those old women. They charge but very little—500 shillings [$6.50]."[295] According to Grace, the "old woman" inserted a "coil" and told her to keep it in place for a few weeks. Grace suffered complications and ultimately needed care for the infection that resulted. She was fortunate enough to find a doctor who was willing to provide services free of charge.

Poverty: A Contributing Factor in Unwanted Pregnancies and Unsafe Abortion

Poverty is a critical factor in both causing unwanted pregnancies and motivating women's decisions to terminate a pregnancy. Contraception can be expensive, and access to more affordable public-sector supplies is limited. For example, according to two Kibera residents, the only government health facility in Kibera—the largest informal settlement in Kenya—faces recurrent contraceptive shortages.[296] In addition, poor women and girls who are discouraged from obtaining family planning methods from public-sector facilities because of negative provider attitudes cannot afford to use private-sector facilities to avoid the stigma and questioning that often accompanies women's efforts to obtain contraceptives, particularly EC. [See Access to Emergency Contraception is Limited, p. 47].

Even when accessible, some contraceptives, such as birth control pills, make women feel nauseous and unwell when taken on an empty stomach[297]—a common phenomenon for those living in poverty. A community organizer in Kibera explains how this can deter poor women from using such methods, "if you're using contraceptives and you're not feeding well it's a problem. . . . Taking pills or injections is not possible . . . because you're feeling bad, you're eating nothing, you can even go two days without food, so you can't use these things. It's a problem."[298]

Further, poverty forces women and girls into situations where they cannot always negotiate condom use during sex. Due to the worsening economic situation and devastating economic impact of the post-election violence that left hundreds of thousands of Kenyans internally displaced,[299] poor women and girls sometimes engage in "survival sex"—trading sexual acts for basic life necessities. A 2003 study by the Center for the Study of Adolescence found that 56% of secondary school students "had exchanged sex for money;"[300] a 2006 study by the Kenyan government and UNICEF found that 30% of teens in certain Kenyan coastal areas traded sex for cash.[301] The study further found that 35.5% of sex acts occurring between children and tourists on the Kenyan coast take place without condoms.[302]

The spread of poverty following the 2007–2008 post-election violence is reported to have sparked a "sex work boom."[303] In 2009, The Daily Nation reported that girls as young as ten years of age were having sex to help feed their families,[304] or to afford necessities like sanitary pads.[305] Sarah's story [see Sarah's Story, p. 21] is one such example. In addition to the power differential that may leave young girls and women with limited authority to advocate for condom use during survival sex, poverty may also pay a role in preventing the practice of safe sex. Some women and girls who resort to selling sex in order to survive are often paid more to engage in unprotected sex.[306] As a 17-year-old commercial sex worker in Mombasa with a six-month-old child explained to a reporter, "I try to use condoms every time, but sometimes they refuse or offer much more money if we don't. If I am offered 200 KES [$3] by a mzungu [white person] for sex with a condom, or 1,000 KES [$15] for sex without, then I don't use condoms. I have to feed my baby."[307]

DISCRIMINATION AGAINST PREGNANT GIRLS IN KENYAN SCHOOLS

Denial of the Right to Education

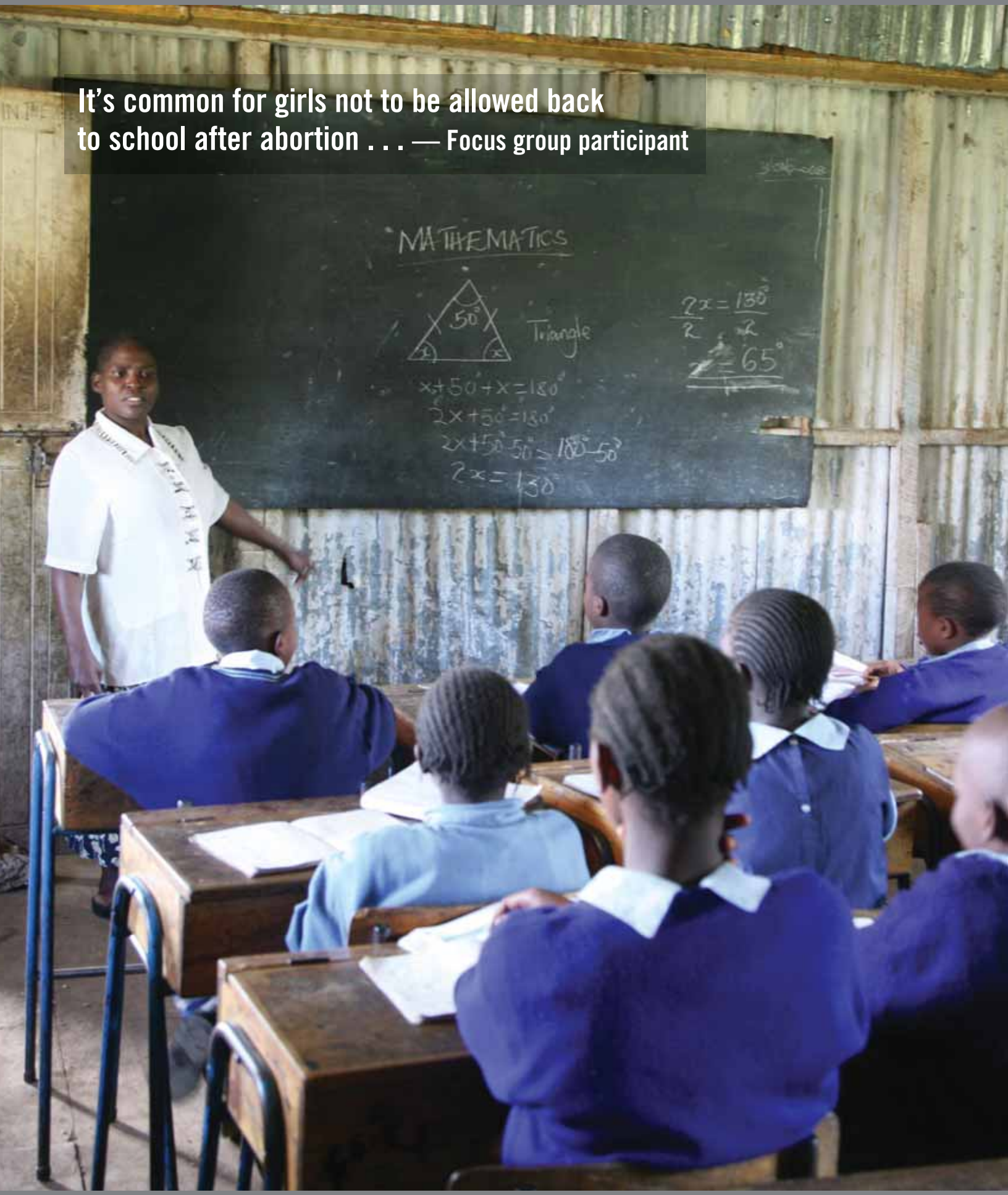
The Committee . . . is concerned at the high rates of teenage pregnancies, . . . the lack of adequate and accessible sex education . . . and the difficulties pregnant girls face in order to continue their education.[308]

—Committee on the Rights of the Child, Concluding Observations for Kenya, 2007

The lack of sexuality education in Kenyan schools, poor access to information about sexual and reproductive health more generally, sexual coercion and violence [see Prevalence of Sexual Violence Contributes to Unwanted Pregnancies, p. 42], and limited access to reproductive health services for Kenyan youths has led to high rates of teenage pregnancy in Kenya. According to the 2003 KDHS, 37.7% of girls have begun child-bearing by the age of 18;[309] and 13% of secondary students surveyed nationally had experienced their first pregnancy by age 14.[310]

One common consequence of teenage pregnancy for girls in Kenya is the forfeiture of educational opportunities: pregnant girls are often expelled or forced to leave school once teachers and school administrators discover the pregnancy. Despite government policies designed to protect a pregnant girl's right to continue her education, 13,000 girls leave school every year in Kenya due to pregnancy, according to a recent study by the Centre for the Study of Adolescence.[311] As a result, only 35% of Kenyan girls between the ages of 16 and 20 are still in school, while almost 50% of boys the same age are, despite the similarity of enrollment numbers when the boys and girls were younger.[312]

Pregnant girls cite the stigma of pregnancy and discrimination by teachers and peers as the main reason that they are forced to leave school.[313] Girls who attempt to return to school after pregnancy face humiliation and isolation—fellow students "do not interact with them freely, partly at the instigation of teachers, who view the returning students as a bad influence."[314] Teachers and school administrators will refuse to allow girls to return to school after giving birth for fear that "other girls would think that it is okay to get pregnant."[315] Since the girls may lack strong support systems, they often are not in a position to challenge mistreatment or expulsion.[316] According to news reports, at the Marinyn Secondary School in James Finlay Tea Estates in Kericho, all but one of twenty-five girls in the 2009 Form One class were forced to drop out of school due to pregnancy;[317] similarly, twenty-eight girls between the ages of 11 and 15 dropped out of a primary school in Kinango District in 2009 after becoming pregnant.[318]


It's common for girls not to be allowed back to school after abortion . . . — Focus group participant
MATHEMATICS
50°
Triangle
x+50+x=180°
2x+50=130°
2x=130°
2x=130°
2
2
x=65°

Denial of the Right to Education, continued...

The Kenyan government's 1996 Return to School policy guidelines provide that "girls who become pregnant should be admitted back to school unconditionally" and that head teachers and education officials should assist in the readmission of girls after the baby is weaned and, if appropriate, help them "join other schools to avoid psychological and emotional suffering."[319] However, implementation of this policy has been poor, with many parents and school administrators and teachers unaware of the policy's existence.[320] Where knowledge of the policy exists, implementation appears to be subject to the discretion of head teacher at the school—there are no monitoring or follow-up procedures and no penalties for noncompliance.[321]

As a result, a 2006 study on Kenyan adolescents' abortion discourse found that "[d]espite the fact that pregnancy no longer legally bars girls from secondary education, young people continue to perceive pregnant girls as being at risk of school expulsion and a disturbingly high proportion see unsafe abortion as the only way to remain in secondary school."[322] Similarly, World Bank experts maintain "that high unsafe abortion rates may be partially attributable to the continued extra-official expulsion of pregnant students from Kenyan schools."[323]

Turning to Unsafe Abortion to Stay in School

Many schoolgirls, unwilling to risk their education because they have become pregnant, terminate their pregnancy in order to continue their education. According to the 2006 study on Kenyan adolescents' abortion discourse, "[s]econdary school students are more likely to pursue abortion as a strategy than their out-of-school age peers."[324] In doing so, they risk—and sometimes lose—their lives. The case of a young orphan girl is one such example. In spite of being orphaned, she had scored top marks on her KCPE (Kenya Certificate of Primary Education) exam and her local Minister of Parliament was helping to fundraise for her school fees. When she discovered that she was pregnant and would not be able to continue on her promising educational path, she sought an illegal, unsafe abortion. She bled to death from the procedure.[325]

Denial of the Right to Education, continued...

Procuring an abortion can also mean risking one's education, placing pregnant girls in an impossible situation. In the early months of 2009, Mary, a young girl in secondary school in Mbita, became pregnant. An orphan who lived with her grandmother, Mary realized that being pregnant and having a child would not allow her to continue with her education. She went to a private provider in Mbita to have the abortion and then returned to school. According to her close friend, who was interviewed for this report, "The teachers knew she had been pregnant. She started bleeding in school, behind the classroom. The teacher called her and said to go to home and be pregnant again. If she couldn't do that, she shouldn't come back. Now she's at home and this has made her not finish school. She won't go back to school because she was chased away."[326] Mary "had the abortion because she wanted to continue to go to school," said her friend; she was so determined to pursue her education, her friend explained, that "instead of waiting for it [the post-abortion bleeding] to be finished she went to school, because it was opening day. So she bled at school."[327]

According to the friend who recounted Mary's story, "it's common for girls not to be allowed back to school after abortion—this is the only one I know of personally but I've heard of many [similar stories]." In an interview with the Inter Press Service news agency, Eliud Kinuthia, the program director of the Forum for African Women Educationalists—Kenya, described a similar experience concerning a girl whose school fees the organization was paying. The Mombasa-based school contacted the organization requesting that it stop paying the girl's fees because she had become pregnant. When the girl lost the pregnancy, the school concluded that she had induced an abortion. Kinuthia told Inter Press Service, "The (school) board was to meet to discuss the pregnancy and the 'abortion', and finally expel the girl from school. I spoke to the head teacher and insisted that this was not a reason to stop paying her fees, and that she had to be allowed (to remain) in school, according to the [government's return to school] policy."[328]

This practice, combined with the pervasive practice in Kenyan schools of expelling or forcing out pregnant schoolgirls, effectively denies girls their right to education on the basis of their pregnancy status; once expelled, the obstacles to eventually completing their degree are considerable.

Barriers to Safely Terminating a Pregnancy

> *I had no money to go to hospital. So I decided to go to those old women. They charge but very little—500 shillings. A friend told me about them. Because I was totally confused, my friend introduced me to where they live and what they do. I risked my life. [They inserted a coil.] It was painful, especially when you sit down it was painful because it goes up. When you sit or sleep you experience pain—it's very painful. I had this for two weeks. After that I go to job as normal, but after two weeks I felt sick, tired and dizzy, and then saw some discharge. Within three days the bleeding started.*[329]
>
> ***—Grace from Dandora***

In Kenya, a woman who wants to safely terminate an unwanted pregnancy must negotiate a maze of misinformation as well as personal, financial, and bureaucratic barriers. Women face multiple obstacles to obtaining a safe abortion in Kenya, due largely to the stigma, lack of legal clarity, and prohibitive costs surrounding the procedure. Although abortion is permitted to preserve the woman's life under Kenya's Penal Code,[330] to preserve the woman's health under the Medical Practitioners and Dentists Board's (Medical Board) Code of Professional Conduct and Discipline (Code of Conduct),[331] and in some cases of rape under the Ministry of Health's National Guidelines on the Medical Management of Rape/Sexual Violence (Sexual Violence Guidelines),[332] women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya's public healthcare system.

Healthcare providers, both inadvertently and deliberately, serve as a barrier to access. In public hospitals in particular, providers often do not discuss abortion as an option when counseling women who qualify for a legal abortion. Some providers refuse to perform a legal termination when requested—either due to a misunderstanding of the law or for personal reasons—or delay the scheduling of the procedure in an effort to dissuade women from terminating.

Women also face structural barriers to access in both public and private healthcare facilities: abortion services may be difficult to obtain due to a lack of provider training or necessary medical equipment. Further, in private facilities, women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe abortion services. While Kenyan women with financial means usually have access to relatively safe abortions performed by private practitioners, most poor women must resort to unsafe and clandestine means.[333] According to Martha Karua, former Minister of Justice and Constitutional Affairs,

> *[q]uite paradoxically and despite the restrictive laws, safe abortion services are available for women from the upper middle class who can afford abortion services from private clinics and hospitals by trained medical persons at a fee. . . .Majority of women, of low social and economic status, cannot afford the fees charged for safe abortion. . . .[A]ccess to the services in public facilities are limited and most doctors prefer to undertake the procedure in their private clinics at exorbitant fees which is way beyond the means of an ordinary woman.*[334]

Lack of Accurate Information about the Abortion Law and Procedure

A 2006 study on Kenyan adolescents' abortion discourse found that "[m]any young people in Kenya are under the false impression that the law prohibits abortion entirely."[335] A 2003 study of 614 secondary students in Kenya found that "almost a third of students (29%) believed, incorrectly, that abortion was never permitted in Kenya, and another 14% reported that they did not know whether it was ever legal or not."[336] Lack of information about the legal status and availability of abortion extends to adults as well. As one doctor explained, "Most of them [women] don't know [the law]. They know public pronouncements that demonize people who have abortions as murderers and everyone shouting abortion is illegal."[337]

As a result, many women do not even attempt to discuss abortion with, or seek abortion services from, a qualified healthcare provider. Information about abortion and safe abortion services appears to come largely from friends or relatives rather than from qualified healthcare providers or other credible, informed sources.[338] Each girl or woman faced with the need for an abortion is dependent upon the knowledge possessed by her particular circle of close friends or relatives. Access to information is therefore quite relative and somewhat arbitrary.

For example, the consensus during a Center for Reproductive Rights focus group discussion among adolescents and young women in Kibera, a large informal settlement in Nairobi, was that "you cannot go to a public hospital for an abortion."[339] Instead, the girls agreed that "the most common way to get an abortion is backstreet and when that fails you go to the hospital."[340] Similarly negative impressions about access to safe abortion through trained providers were expressed during another Center for Reproductive Rights focus group discussion in Suba District. As one participant said, women "don't go to doctors to terminate their pregnancies. Doctors don't terminate pregnancies."[341]

Women's lack of information and awareness about the existence of safe and legal abortion services stems from both the criminalization of the procedure and the consequent stigma surrounding it. Women are reluctant to seek help from qualified healthcare providers or counselors because of the shame and fear of legal ramifications associated with abortion. As a woman in a focus group discussion in Mombasa explained, "The problem is that abortion is not legal in Kenya and there is a lot of stigma surrounding abortion. You don't want to seek help publicly. You go to a private, unqualified hospital."[342]

The stigma associated with sexuality and abortion is fueled by school curricula. A 2006 study found that Kenyan adolescents were taught, as part of the official secondary school curriculum that "sexual intercourse and induced abortion lead to a wide range of chronic health and social problems."[343] For example, an excerpt from the Kenya Certification Secondary Education *Social Education & Ethics Exam Review Book* reads, "Young people who procure abortion often end up leading depressed, frustrated, unwholesome and lonely lives which usher them into a further abyss of depravity and drug addiction."[344]

A vague understanding of the law as highly or entirely restrictive combines with the stigma—often associated with criminalization—surrounding the procedure to set the stage for misinformation and misperceptions about the nature of the procedure itself. Deterred from consulting with qualified healthcare providers and without meaningful access to reliable information about safe and legal abortion, women rely on their lived experiences. For many, this is clandestine, backstreet abortions. Although properly performed abortion is one of "the safest procedures in contemporary medical

practice, with minimum morbidity and a negligible risk of death,"[345] there is a belief among some Kenyan women that abortion is inherently unsafe—and cannot be otherwise.

This belief was summed up by a participant in a Center for Reproductive Rights focus group discussion in Suba District, "the government is not authorized to practice abortion. . . . They are not allowed because abortion can lead to severe bleeding and eventually death."[346] One woman from Nairobi, who had recently procured a backstreet abortion, made no distinction between safe and unsafe abortion, remarking that "one can die when doing an abortion."[347] A community health worker from Mbita, who counsels HIV-positive women on abortion, tells her clients that "abortion may lead to death . . . [and] to infections and other diseases."[348] She stated that "we are not trained on counseling for abortion. We just say what we know from our own experience."[349] With exposure only to backstreet or unsafe abortion practices, many Kenyan women understand abortion to be an inherently life-threatening procedure.

Even when women are able to access safe abortion services, they remain fearful that they are risking their lives. One young woman who procured an abortion from a reputable private clinic in Kisumu, staffed by trained doctors and reproductive healthcare specialists, said of her experience, "I was really terrified at that time. I thought I was going to die. . . . Thank god I survived it. . . . I heard you can die from herbals or other sources. I asked the doctor if I would survive but I wasn't convinced until I did."[350]

The Prohibitive Cost of Safe Abortion

The cost of safe abortion is a critical factor in determining a Kenyan woman's access to the procedure. For those who can afford it, safe abortion services are relatively easy to access; for poorer women, the costs can be prohibitive. Poverty affects women disproportionately: female-headed households in Kenya experience higher incidences of poverty than their male counterparts, in both rural and urban areas.[351] In a country where almost 40% of the population lives on less than two dollars a day and 52% of the population lives below the national poverty line, safe abortion services are out of reach for many.[352]

For some women, cost is a complete deterrent. For others, it delays the procedure until they have raised the required amount of money,[353] increasing the risk of complications from the termination and the potential threat posed by the pregnancy to their mental or physical health. For still others, it forces them to seek help elsewhere and risk obtaining an unsafe abortion from an unqualified and untrained individual or herbalist who charges significantly less.

The cost of safe abortion services varies widely. According to a doctor at Kenyatta National Hospital (KNH), a termination costs approximately 1,000 shillings ($13).[354] A private provider in Nairobi, interviewed for this report, said that he charges approximately 9,000 shillings ($118) for a termination;[355] another private clinic in Kisumu charges between 5,000–10,000 shillings ($66–132), depending on the stage of pregnancy.[356] A clinical officer at Kisumu East District Hospital who offered abortion services privately explained that the price depends on gestation: "less than two months is 5,000 shillings [$66]. More than two months, every week adds 2,000 shillings [$26]."[357]

To put these figures into further perspective, one provider who offered terminations in Nyalenda, an informal settlement in Kisumu, said that he charged between 1,500–2,000 shillings ($20–26) for a safe abortion in his clinic. He explained that even these prices were prohibitive for many and that a lack of money prevents women from accessing his services.[358] Another qualified provider in Manyatta, an informal settlement in Kisumu, explained that his price for terminations depends on what the patient

can afford: "Here it's a slum and women are unable to pay 1,000–2,000 shillings [$13–26]. . . . I start at 500 shillings [$6.50] and up."[359]

In contrast, herbalists and unqualified individuals charge between 300–500 shillings ($4–6.50) for their services.[360] One focus group participant in Suba District explained why women resort to herbalists: "The herbalist is cheaper than the hospital. They just go to the bush and get materials so it's cheaper. Also, herbalists are accessible and the hospital is far and you have to pay for transport. It's easily accessible to go to herbalists."[361] A private provider in an informal settlement in Kisumu agreed:

> *Women know about private providers but still go to quacks because they are cheaper. Quacks induce and then [the women] go to a government hospital to complete. This is cheaper than going straight to providers but the risk is complications.*[362]

The high cost of safe abortion services is sometimes driven by the perceived blanket illegality of the procedure. As one clinical officer explained, "Because it's illegal there are people that are overcharging the patients and extorting money from patients."[363] Private practitioners are able to charge high fees because the number of qualified providers is limited. As an OB/GYN professor at Moi University explained:

> *Those who are ready to do it [perform abortions] are asking for more money than they would otherwise ask for if it was just a simple medical procedure that was legal. Because it's illegal the market forces are such that there are few that are doing it and the access is limited, so this keeps the cost high. If it became decriminalized there would be no need to charge a lot of money for a procedure that they could get at market price that was competitive.*[364]

A member of the Suba District Health Management Team expressed a similar opinion, explaining that some providers "overcharge because people who seek abortion services are desperate."[365] This occurs in public health facilities as well, usually in the form of a bribe or under-the-table fee paid to providers in exchange for services.[366] Costs are also inflated because only doctors are officially allowed to provide abortions, preventing other levels of healthcare providers who typically charge lower prices for their services from joining the open market.[367]

Providers as Barriers to Safe Abortion Services

Misinformed and Fearful

> *In Kenya, health workers especially doctors have not exploited the window of opportunity in the legislation to save women who suffer or potentially will suffer complications of unsafe abortion.*[368]
>
> ***— District Medical Officer of Health, Ministry of Health***

The lack of clarity surrounding the abortion law is evident in the varied understandings that healthcare providers have of the abortion law and its exceptions. [See Kenya's Abortion Law is Restrictive and Unclear, p. 31]. In some circumstances, providers themselves may unwittingly create barriers to women's access to safe abortion. Many providers believe that abortion is simply illegal and thus refrain from both offering services and referring women to other providers. Other healthcare providers

erroneously believe that the law requires the written approval of gynecologists and psychiatrists—both a rarity in Kenya—to perform a termination, creating additional barriers to access and resulting in few women being able to benefit from a safe and legal abortion in public hospitals.

Some healthcare providers interpret the law so narrowly that they fail to identify qualified cases for legal termination and are unable to appropriately counsel women on their options. Unaware that a health exception and, in turn, a rape exception, have been read into the law, many providers go by the literal text of the Penal Code and interpret it quite conservatively, understanding abortion to be allowed only as an emergency procedure to immediately save the woman's life. Others, uncertain as to the content of the law, simply choose not to take the risk at all. As Dr. Joseph Karanja, an obstetrician-gynecologist who teaches at the OB/GYN department at the University of Nairobi/KNH, explained, "many [healthcare providers] will try to avoid getting into a situation where the law can question them. So they will play it safe meaning they will deny care even when it is deserved."[369]

This conservative approach to abortion provision also influences referral practices. A clinical officer with a private clinic in Mbita related, "When I was being trained in clinical officer training school, I was told that abortion is not legal. I developed an attitude after the training so I don't encourage it in my clinic."[370] If someone requests a termination, the clinical officer simply recommends that they see a gynecologist: "I don't refer them to a particular gynecologist because I don't want to be complicit." Since there are no gynecologists in Mbita, or in the nearest sub-district and district hospitals,[371] such a referral is essentially useless and fails to provide women with meaningful access to safe abortion services.

"People are the Policy:" Negative Provider Attitudes and Beliefs as Barriers

The absence of policies or protocols specifically addressing abortion, or abortion-related referrals, means that providers have wide latitude to exercise their discretion in service provision. This can be a serious barrier for women who require or qualify for a legal termination. As discussed in detail later on [see Nurses and Clinical Officers: An Underutilized Resource in Addressing Unsafe Abortion; Beyond the Impact on Women: Providers and the Healthcare System, p. 117], for a variety of reasons related to the restrictive legal regime in Kenya, some providers choose not to perform abortions in their practice. Others object to abortion provision more generally, citing personal religious and moral beliefs—these providers not only refuse to offer services themselves, but may also prevent or delay provision of services by others.

A former nurse-manager of the OB/GYN department at Kenyatta National Hospital (KNH) recounted:

> *[At KNH, we] had doctors in [the OB/GYN] department who would never provide [abortions]. We had a mentally [disabled] girl who was sick and pregnant. The decision was unanimous that the pregnancy was to be terminated but the doctor that was there that was most senior was anti-choice and said she couldn't do it. [The girl] was almost at full term when we realized that the woman was physically unable to deliver [due to] high blood pressure and pelvic problems and we had to do a hysterotomy. The policies are on paper, but people are the policy. . . . The doctors in charge are supposed to be translating the guidelines and putting them into action but some doctors never do it. This is why values clarification is so important at all levels.*[372]

As one long-practicing obstetrician-gynecologist explained, delaying tactics are also common: "There will be no outright 'we should not do it,' it will be delaying tactics and the woman gets frustrated and goes home."[373] Dr. Boaz Nyunya of Moi University explained that when "objecting" doctors list cases in the order they are to be addressed, they "will list a termination case as eight out of ten so that a patient is there for a week. [They are] letting them wait because there is a feeling that they should not get priority and it's not a common procedure and not something people like to do in public institutions."[374]

According to Dr. Karanja, based on his experience at KNH, the "anti-choice providers" typically do not delay care in life-threatening situations, defined as physical threats to the woman's life, such as cancer. However, situations perceived as "non-life threatening" may result in a denial of services. Often, these are circumstances relating to threats to a woman's mental health, a far less understood or respected grounds for termination in Kenya. Dr. Karanja described an incident at KNH, relating to a delay in termination for a rape survivor:

> *We do ward rounds on a daily basis or every other day. Once we find that a case has been delayed we put our foot down and we say that treatment should be started straight away. One time there was a physically disabled girl from one of the peri-urban slums and there was such delaying tactics. She had been referred from Nairobi Women's Hospital because she had been raped. She was in her second trimester so Nairobi Women's didn't feel capable of dealing with her case. I found her in the ward and asked why we are delaying with TOP [termination of pregnancy]—once they've been referred it means the doctors had already recommended [termination], so it had the support of several doctors. . . . [W]hen there are specialists who are supportive, they will give instructions that the orders should be effected.*[375]

These delaying or deterrent tactics are particularly common in public healthcare facilities. Public healthcare providers are perceived as having negative attitudes towards termination, regardless of the circumstances. Interactions with staff are unfriendly and unhelpful, with providers refusing to even counsel clients on termination options. A nurse with a private practice in Kisumu recounted, "In [Nyanza] Provincial District Hospital they [women] get a rough time there, so they don't go there. They don't know where to go in a public hospital. People are very rough to them. They don't talk to them, rarely help them. They are verbally abusive so people don't like going there. Instead, they'll go to a quack. There needs to be a change in attitude by people working in public hospitals."[376] Some major provincial hospitals do not provide terminations under any circumstances. For example, abortions are not performed in Coast Provincial General Hospital, the largest hospital in Coast Province, according to a nurse who has worked there for the last two decades.[377]

Delaying tactics are not unique to public hospitals: media reports indicate they were also employed by healthcare staff in camps for internally displaced people following Kenya's post-election violence. A 2009 Daily Nation article told the story of Ruth, who was brutally gang-raped during the post-election violence.[378] She awoke three days later, in a hospital, with no recollection of how or when she had arrived there. A few months later she realized that the gang-rape had left her pregnant. The article recounted that "she reported to the health clinic within the camp that she has missed her period. She was tested, but the medical staff were evasive about the results although they continued counselling her. After six months, [Ruth] wanted to terminate the pregnancy but was not allowed to."[379] This denial directly contravenes the directives laid out in the Ministry of Health's Sexual Violence Guidelines, which

permit abortion in the case of rape.[380] Ruth was forced to carry the pregnancy to term, despite the fact that "[d]ue to the damage to her body after the gang-rape, [she] couldn't give birth normally."[381]

The personal beliefs of the available provider often determine access to care. The lack of clear, authoritative decision-making criteria to assist providers in determining when women qualify for a legal abortion make such arbitrary decisions difficult to challenge. Women are rendered powerless, unable to demand the right to the provision of legal medical services. In addition, where uncertainty and the fear of criminal liability hold sway, few healthcare workers will feel confident in challenging the denial of lawful services to women, allowing individual discretion and personal beliefs to dictate medical service provision. The result is that a provider can deny legal abortion services, based on his or her own criteria and without repercussions, due to the fear, stigma, and uncertainty surrounding the procedure. As Dr. Karanja noted, "[i]n a district where there is only one gynecologist and he's not sympathetic then there may not be any [termination] service[s] at all in the public hospital."[382]

Women Encounter Provider Stigma and Abuse

Women who are able to access abortion services may be subject to degrading treatment by providers, including verbal abuse and the denial of pain medication or anesthesia. This poor treatment, which stems from the social stigma associated with abortion in Kenya, is strikingly similar to the abuses experienced by women who receive post-abortion care. [See Cruel and Degrading Treatment Characterizes Provision of Care. p. 92].

A rape trauma counselor interviewed for this report told of one of her clients who had sought an abortion after being brutally raped and becoming pregnant. The young woman went to a private facility in downtown Nairobi, recommended by her sister. Throughout the procedure, for which she was given no anesthesia, she was verbally abused by the two male providers who attended her. They said, "You will never do this again, come out and see what you have done so you don't go opening up your legs again to other men."[383] According to her lawyer, they "brought the fetus in a bucket and put it in her face and said you need to stop spreading your legs for everyone."[384] The woman suffered post-abortion complications from the procedure but refused to seek further care.[385]

Failing to provide women with anesthesia or pain medication before they undergo an abortion is not uncommon in Kenya. A 2004 study conducted by Ipas and the Ministry of Health on unsafe abortion in Kenya found that "[i]n general, women who presented at the hospitals with incomplete abortion, reported that the most traumatizing aspect of their abortion experience was the bleeding and the 'excruciating pain.' Women likely to have had induced abortion reported that they had undergone additional trauma from the surgical procedure, performed without the benefit of pain control."[386]

According to the World Health Organization (WHO), "[m]edication for pain management should always be offered"[387] before performing an abortion. The WHO further states that "[p]roviding adequate pain management [during abortion procedures] does not require a large investment in drugs, equipment or training. Neglecting this important element needlessly increases women's anxiety and discomfort and seriously compromises quality of care."[388]

Poor Regulation of Private Practice and Abortion Services

The vast majority of terminations in Kenya are performed by private practitioners. This means that most abortions are carried out in a sector that is inherently less government-regulated than the public sector and is also not particularly well-regulated by the relevant bodies charged with private practice oversight, such as the Medical Board or the Clinical Officers Council.[389] According to one nurse from the National Nurses Association of Kenya, "Private practice is not very well-regulated so anyone without much training can pretend to offer services. You can get a license from a doctor and just open a clinic and be a quack and not trained all. This happens quite often. Even in Nairobi. And not just in the slums."[390] Unable to distinguish between qualified and unqualified providers, women unknowingly obtain services from unqualified individuals.[391]

A 1999 study on unsafe abortion conducted by the Center for the Study of Adolescence examined community perceptions of provider safety and found that "community members find it difficult to assess how safe or unsafe a provider is. . . .[S]ince untrained providers mask themselves as doctors wearing white coats, it may be difficult to ascertain who is a trained doctor and who is not."[392] According to one clinical officer interviewed for this report,

> *Quacks are a big problem. The instruments they use are not clean or sterilized and they are not examining the patient correctly. They can end up rupturing the uterus. You never know who is a quack and who is not until they are caught and the clinic is closed. Patients don't know how to know who is a quack and who is not.*[393]

While the law may deter many legitimate providers from offering services, it does not do the same for illegitimate and unskilled providers. Precisely because they operate clandestinely or are not registered, it is harder to hold them accountable for their actions.[394] Women are also prevented from reporting malpractice or abuse because to do so may mean risking criminal charges themselves.

Few Avenues for Redress

> *A colleague [in a public health facility] refused to agree to a termination after a woman's tubal ligation went wrong. There was nothing to do about it [once he'd refused] and the woman had to carry the child to term.*[395]
>
> ***—Obstetrician-Gynecologist, Kisumu***

Since most women are unaware of when they may qualify for a legal and safe abortion,[396] they are unlikely to seek redress when care is denied or delayed. Denying a woman a lawful therapeutic abortion in a public health facility could be considered medical malpractice, defined, in part, as the "failure to properly treat a patient's medical condition."[397] In spite of the gravity of the offense, if a woman wishes to contest her provider's denial of care, there are few avenues for redress. Kenyan law does not require health institutions to establish formal internal complaint mechanisms. The Medical Board chairperson confirmed that establishing a complaint mechanism is not a prerequisite for the registration of a medical facility, and that failure to do so does not result in any penalties.[398] Large hospitals often have suggestion boxes, and patients can also make verbal complaints to staff members, which are then supposed to be addressed by the relevant department head.[399] However, as former Kenya Medical Association Chairman Dr. Stephen Ochiel noted, "this is an informal process—not formalized."[400]

Further, filing a complaint with the Medical Board, which has the authority to discipline medical practitioners for professional misconduct or unethical behavior, is unlikely to offer any form of meaningful redress. According to a 2004 study by the Kenya Institute for Public Policy Research and Analysis that analyzed the regulation and licensing of healthcare providers in Kenya, "[t]he Medical Practitioners and Dentists Board, which is empowered to be the overall regulator of all medical practitioners, has not strongly enforced disciplinary action on those involved in malpractices and negligence."[401] The Medical Board's poor regulation practices, the study concluded, has resulted in only "partial enforcements of regulations," no "clear laws to protect patients against negligent health staff including doctors," and a "reluctance" to discipline irate practitioners/colleagues.[402] These conclusions were confirmed by the Center for Reproductive Rights and FIDA Kenya in a 2007 interview with the legal advisor to the Medical Board, who "noted that only 4% of complaints pass the initial screening stage, and there are currently only 10 cases being heard by the tribunal."[403] Despite the low number of cases that appear before the tribunal, the Medical Board takes an average of one year to resolve a case.[404] The usefulness of this avenue of redress for a woman in need of an immediate remedy is clearly limited.

In addition, there appear to be no clear disciplinary rules addressing the denial of legal medical care and obligating practitioners to refer such patients to another provider willing to provide the necessary services. According to the chairman of the Medical Board, there are no provisions in the Board's Code of Conduct that explicitly address providers' moral objections to offering a legal medical service.[405] He noted, "If the provider says he doesn't agree to this, the patient has to look for someone who could be more sympathetic."[406] Should a woman's doctor deny her access to a safe and legal abortion, the onus is on her to find another provider, representing yet one more hurdle.

In addition, the Medical Board's chief executive officer, Daniel Yumbya, made clear that there are no penalties for providers who refuse to perform services: "If [the providers] say it's on religious grounds then we may not punish them."[407] Although Yumbya states that they are "supposed to refer" these cases to other providers,[408] the Code of Conduct contains no explicit language requiring referrals, other than in an appendix that contains excerpts from the International Code of Medical Ethics.[409] Further, Yumbya himself does not discuss the obligation to refer.[410] The fact that a doctor will not be disciplined for refusing to provide services fails to address whether he or she will be disciplined for neglecting to refer. These interpretations—and the lack of clarity on what is required of doctors in this situation—represent an additional barrier to women's access to abortion and allow a provider's personal beliefs to dictate health outcomes and access to legal medical procedures.

International Medical Standards on Provider Refusals to Offer Services on Religious or Moral Grounds

- International medical ethical standards, such as those established by the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO) offer guidance on how to regulate circumstances in which a provider refuses to offer abortion services based on religious or moral beliefs.[411]
- The WHO and FIGO both specify that physicians who religiously or morally object to performing a procedure have a duty to refer the patient to another provider who does not object.[412]
- Objecting physicians also have a duty to treat an individual whose life or health is immediately at stake, and to "provide timely care when referral to other practitioners is not possible and delay would jeopardize the patients' health and well-being."[413]
- The WHO makes clear that hospital managers should ensure that trained staff, whatever their perspective, "are available at all times to provide emergency care for abortion complications,"[414] and that a public hospital, clinic, or health center "cannot endanger women's lives or health by refusing services allowed by law."[415]
- Lastly, FIGO affirms that physicians have "an ethical obligation, at all times, to provide benefit and prevent harm."[416]

Structural Barriers: Dearth of Trained Providers and Equipment

> *There are not enough providers trained in termination of pregnancy—we need to train more.*[417]
>
> ***—Dr. Karanja, Department of OB/GYN, University of Nairobi/KNH***

The limited number of healthcare providers trained to perform abortions also dramatically restricts women's access to safe abortion services—and magnifies concerns about provider barriers to access, given that few providers are able to offer services. Often, there may be no trained abortion providers on staff when a woman arrives at a healthcare facility. To obtain a safe abortion, women must typically be referred to another healthcare facility where there is a trained provider on staff, creating logistical hurdles and increasing women's financial burden by adding transportation costs.

The lack of provider training is due primarily to poor government policies that have failed to clarify who may offer safe abortion services and under what circumstances, and to ensure that enough providers are sufficiently trained in the procedure. At present, doctors are the only cadre of healthcare providers who receive explicit training in school on how to perform terminations. According to professors at both

the University of Nairobi and Moi University medical schools, all medical students are taught the basics of the procedure and therefore general practitioners should be able to provide termination services.[418]

However, there are a number of limitations to their training. According to Dr. Njoroge Waithaka, head of the OB/GYN department at KNH, the University of Nairobi teaching hospital, and chairman of the Kenya Obstetrical and Gynecological Society, and Dr. Zahida Qureshi, who teaches in the OB/GYN department at the University of Nairobi/KNH, the training focuses on the manual vacuum aspiration (MVA) technique.[419] Students do not learn how to perform a dilation and curettage (D&C) for termination or incomplete abortion purposes.[420] According to Dr. Karanja, who also teaches in the OB/GYN department at the University of Nairobi/KNH, some gynecology residents may be trained in dilation and evacuation (D&E) on the job or during residency; however, this type of training is limited to gynecology residents alone.[421] This restricts the window of opportunity in which many women have access to safe abortion, as MVA can be used to induce abortion only up to 12 weeks' gestation.

Further, as Dr. Qureshi explained, the focus of the training is on using MVA to manage complications of unsafe abortion—less time is spent on safe abortion provision.[422] This may be due, in part, to the fact that opportunities for hands-on clinical experience in abortion provision are limited. According to Dr. Karanja, there are approximately one or two termination cases at KNH—the largest teaching hospital in Kenya—per month.[423] As Dr. Waithaka noted, "These are the only opportunities [for doctors in training] to learn how to terminate before they go out to the regions and have no senior doctors to supervise them."[424] Although the "difference between [post-abortion care] and termination is very small. . . [the medical students] don't have the experience [in abortion provision] by the time they're qualifying."[425] As such, he explained, "the general medical doctors don't really know how to terminate."[426]

In particular, the Ministry of Health has failed to ensure that an adequate number of providers are trained in second-trimester abortion procedures, severely limiting women's access to safe abortion after the first trimester. Due to insufficient training of healthcare providers, second-trimester abortions can be performed by only gynecologists, of which there are only 290 in the entire country.[427] According to Dr. Karanja, "Most women don't have access for second trimester [abortions]."[428]

In addition to training gaps, providers' lack of clarity on the content of the abortion law, and the circumstances under which abortion may be legally performed, has heightened the fear and stigma surrounding the procedure, deterring providers not only from offering services but from being trained to offer safe abortion services. This has further limited the number of practitioners capable of providing safe services when needed or permitted under the law.[429]

Finally, a lack of MVA equipment [see Shortages of MVA Equipment, p. 108] prevents timely access to first-trimester safe abortion services. Ill-equipped facilities are forced to refer women to the nearest facility possessing an MVA kit, adding to transportation costs and waiting time.

The Social and Legal Risks of Procuring an Abortion

Procuring an abortion in Kenya, whether safe or unsafe, carries social and legal risks for women, such as arrest and prosecution as well as stigma and social condemnation [see Rosemary's Story: Living with Stigma, p. 71]. For example, schoolgirls may risk losing their opportunity to complete their education. [See Discrimination against Pregnant Girls in Kenyan Schools, p. 53].

Arrest and Prosecution

> *I was scared. I haven't done that [procured an abortion], it was just the first time. I don't know what I would do with that baby, I had no choice. I was worried that doctor would tell the police—I've heard about that happening. I had no other option.*[430]
>
> ***— Elizabeth from Kayole, Nairobi***

Women who procure an abortion often fear arrest and justifiably so—women in Kenya are regularly arrested for unlawfully procuring an abortion. A community organizer from Kibera noted that "many women have been arrested. . ." on abortion charges.[431] Similarly, Evelyne, a long-time Kibera resident and the mother of a young girl who died from an unsafe abortion said that, in Kibera, "[e]veryone is afraid. People in Kibera get arrested. If they find a fetus somewhere they will search all the women in the area to see who is bleeding and they will turn the woman over to the chief and over to the police."[432]

Data on the prevalence of such arrests and prosecutions is not collected by the central government or easily available to the public. However, a reproductive rights researcher who is currently collecting abortion decisions from magistrate's courts across the country stated that in the lower courts in Nyeri and Kisumu, there are approximately three cases being tried per week in which women are charged with procuring an illegal abortion.[433] The researcher believes that in Nairobi—and in the Kibera courts especially—the number of cases per week must be higher "because you can more easily get caught in Nairobi after performing abortion."[434]

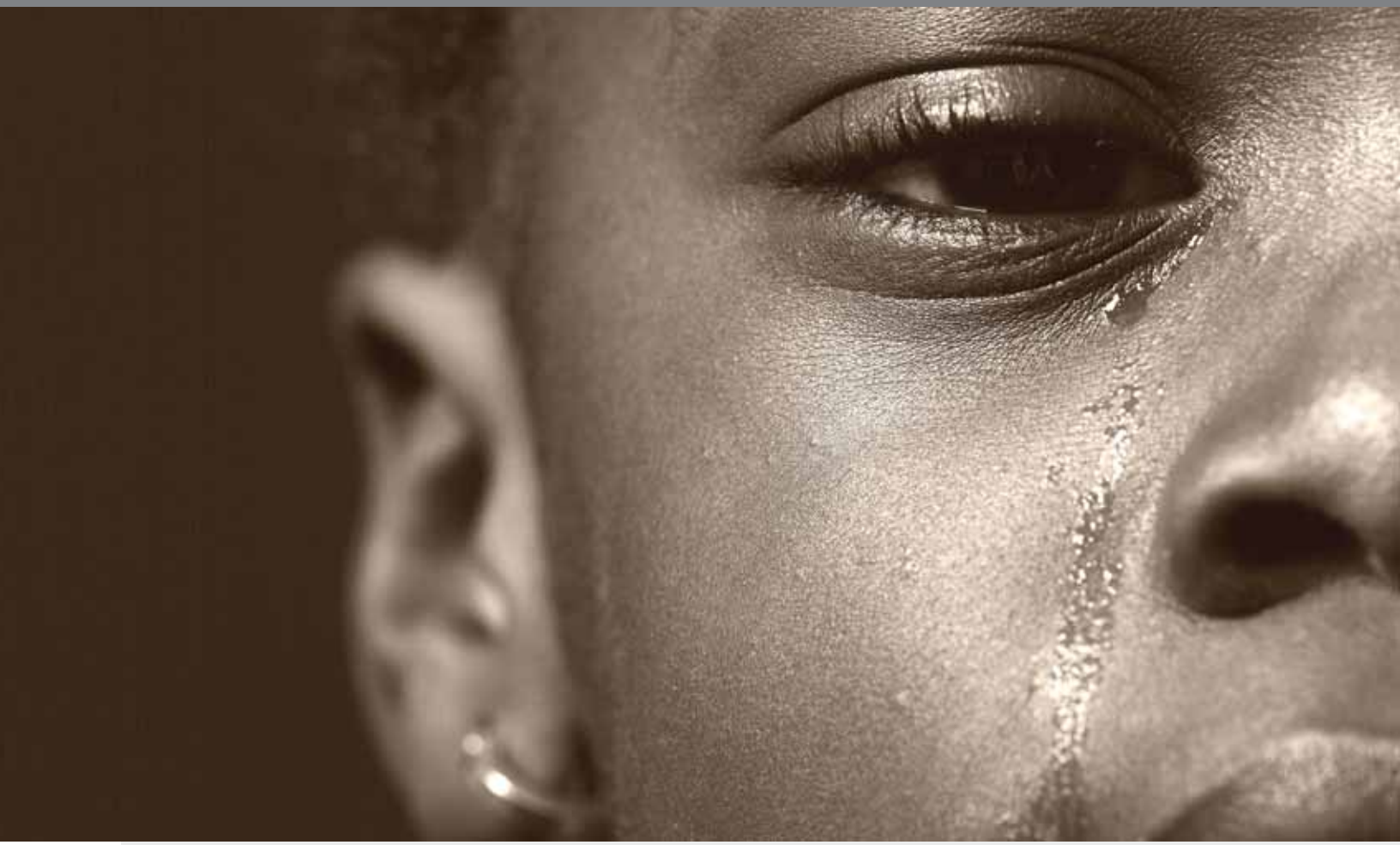
The court decisions indicate that the women tend to be reported to officials by their neighbors and families. Evelyne of Kibera concurred, explaining that "[p]eople in the community tell the chief, he tells the police and then you are arrested. . . . If neighbors knew about [an] abortion they would tell the police."[435] Rarely, it seems, do the police investigate a suspected illegal abortion case without having been referred by neighbors or family. The researcher's findings also reveal that those providing abortions are not arrested as frequently as the women who receive them; according to the researcher, "normally the provider will have fled or can't be found."[436]

Girls and women charged with procuring an unlawful abortion rarely have legal representation. The community organizer in Kibera explained that women arrested in Kibera "go to court [the Kibera Law Courts] and defend themselves."[437] Similarly, of the abortion cases that the reproductive

rights researcher reviewed from Nyeri and Kisumu, not one of the women or girls tried had legal representation at trial.[438] Ten out of twenty cases examined involved schoolgirls, some of whom were minors.[439] In all the cases, the women pled guilty to the charges; as the researcher noted, "evidence doesn't even have to be called."[440]

The researcher's findings further indicate that while women typically plead and are found guilty, they are rarely sentenced to prison terms. In the majority of the cases studied by the researcher, the magistrate sentenced the convicted woman to two years' probation rather than the maximum seven years' imprisonment. In some cases, women were simply admonished by the magistrate.[441] As the researcher explained, "Magistrates are alive to the fact that abortion is happening. . . ."[442] The researcher concluded that the magistrates' sympathy towards the women, cognizance of the overwhelming congestion in Kenyan prisons, and the fact that the women tried are typically first offenders lead magistrates to issue community service orders instead of jail terms.[443] However, this is not always the case—one woman interviewed for this report told of her friend who was convicted of procuring an illegal abortion and sentenced to five years in jail.[444] She is still serving her sentence at Langata Women's Prison.[445]

While jail time may be the exception, accused women who cannot afford bail might remain in remand pending their trial and judgment. Cases can take an average of one year to go to trial: in Nyeri, girls who were arrested in July 2006 were in remand until July 2007, when the decision in their case was finally handed down.[446]



ROSEMARY, A YOUNG WOMAN, WAS BRUTALLY RAPED,
and then genitally mutilated by two men in Nairobi. In addition to dealing with the trauma of this experience, the rape had left her pregnant. Too ashamed to tell anyone about the rape, Rosemary went to her sister for advice on how to deal with the pregnancy. Her sister brought her to a private clinic where she could procure a safe abortion. Rosemary told no one but her sister about this experience.

Rosemary's Story: Living with Stigma

Abortion is a highly stigmatized procedure in Kenya. A woman who procures an abortion, whether safe or unsafe, legal or illegal, risks community and family condemnation.[447] Women who have abortions go to great lengths—even risking their lives and health—not to be discovered by family, friends, or neighbors. Women often fear the potential stigma and shame associated with the procedure more than the possibility of arrest and imprisonment. Rosemary's story illustrates the nature and impact of this type of stigma.

Rosemary, a young woman, was brutally raped and then genitally mutilated by two men in Nairobi. In addition to leaving Rosemary severely traumatized, the rape also left her pregnant. Too ashamed to tell anyone about the rape, Rosemary went to her sister for advice on how to deal with the pregnancy. Her sister brought her to a private clinic to procure a safe abortion. Rosemary told no one but her sister about this experience.

According to her trauma counselor, Rosemary's sister then told everyone—her family and community—that Rosemary had obtained an abortion. Now, said the lawyer investigating her case, "she has no support. [Instead, she's suffered] lots of insults. [From] her mom included."[448] Her trauma counselor said that Rosemary is particularly upset by her mother's reaction: "She wants our support and her mother's support. Her mother has rejected her."[449] Rosemary has still not told anyone in her family about the rape that led to the unwanted pregnancy.[450]

The shame and disgrace that Rosemary is made to feel by her family and community has severely affected her quality of life. According to her trauma counselor, she "started feeling like everyone was talking about her and started having social phobia. She can't go out. She leaves the house early in the morning [for her counseling session] and comes home very late so no one will see her."[451] Rosemary is currently suicidal; her trauma counselor and lawyer are deeply concerned about her well-being and safety.

RIGHTS IMPLICATIONS OF BEING FORCED TO CARRY A PREGNANCY TO TERM

The rising rates of unwanted and unplanned pregnancies among women under 20 years of age not only compromise their reproductive health but deny a majority of them opportunities to complete their education and acquire decision-making skills which will enable them to make informed choices about their fertility.[452]

— The African Platform for Action, adopted by African governments participating at the Fifth African Regional Conference on Women

The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women's lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.[453]

—CEDAW Committee, General Recommendation 21

Denied access to safe and legal abortion and unwilling to risk the consequences of unsafe and illegal abortion, some women are forced to carry an unwanted to unplanned pregnancy to term. This has serious implications for her mental and physical health, her physical, mental, social, and intellectual well-being, and her ability to realize other fundamental human rights. It can also determine the extent to which a woman can realize her potential and participate in both private and public life.

International and regional human rights bodies have acknowledged that being forced to carry a pregnancy to term violates women's human rights, including a woman's right to health and to be free from torture and cruel, inhuman or degrading, treatment. For example, in its General Comment 24 on Women and Health, the CEDAW Committee acknowledges that, for young girls, there may be a "physical and emotional harm which arise[s] from early childbirth."[454] The CEDAW Committee has also recognized that the health risks experienced by women may have consequences for the health and lives of their existing children.[455] This impact is clear in the Colombian case of Marta Gonzalez. She

was a 34-year-old mother of three when she was diagnosed with uterine cancer early into her fourth pregnancy. A public hospital refused to give her the abortion she requested so that she could undergo chemotherapy and radiation treatment.[456] Denied available cancer treatment because of the possible risk to the fetus, Marta was forced to carry her pregnancy to term without treatment and died several years after giving birth. She spent her final months trying to collect donations for her four children so they would be able to have a place to live and afford an education.[457]

In addition, the Human Rights Committee, charged with interpreting the International Covenant on Civil and Political Rights, has recognized the link between being forced to carry to term a pregnancy conceived from rape and cruel, inhuman, and degrading treatment. The Committee has noted that in order to assess compliance with the provision prohibiting torture and cruel, inhuman, or degrading treatment, it needs "to know whether the State party gives access to safe abortion to women who have become pregnant as a result of rape."[458]

Three Case Studies

The understanding of the rights violations at issue in carrying an unwanted pregnancy to term is reflected in the interpretations, decisions, settlements, and concluding observations issued by international and regional human rights bodies. The following three cases—which came before the European Court of Human Rights, the Human Rights Committee, and the Inter-American Commission on Human Rights, respectively—address some of these rights violations.

***Tysiac v. Poland* (2007)**

The European Court of Human Rights has recognized that being forced to carry a pregnancy to term can have implications for women's health and rights. *Tysiac v. Poland* involved a Polish woman, Alicja Tysiac, who was severely visually impaired and was denied an abortion to protect her physical health. Pregnant for the third time, she consulted three ophthalmologists who concluded that carrying the pregnancy to term constituted a serious risk to her eyesight but refused to issue a referral for abortion, which was required under Polish law. Although a general

practitioner finally provided Alicja with such a document, the head of gynecology and obstetrics department at a Warsaw clinic declined to terminate the pregnancy, stating that there were no medical grounds for a therapeutic abortion.[459] With no procedures available to review the doctor's decision or to provide Alicja with a timely abortion, she had no option but to carry her pregnancy to term. After the delivery, her eyesight seriously deteriorated; an official panel declared Alicja to be a significantly disabled person.[460]

The European Court of Human Rights decided the case in Alicja's favor, finding that Poland violated her right to respect for her private life—a right meant to "protect the individual against arbitrary interference by public authorities"[461]—by failing to institute procedural safeguards regarding access to therapeutic abortion. It ruled that Poland has an obligation to ensure effective access to legal abortion:[462] "Once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it."[463] The Court stated that "measures affecting fundamental human rights [must] be, in certain cases, subject to some form of procedure before an independent body competent to review the reasons for the measures and the relevant evidence."[464] The Court held that such a procedure should "guarantee to a pregnant woman at least a possibility to be heard in person and to have her views considered," and "the procedures in place should . . . ensure that such decisions are timely so as to limit or prevent damage to a woman's health which might be occasioned by a late abortion."[465]

The Court then awarded Alicja EUR 25,000 (approximately $34,000 or 2,600,000 shillings) in damages for "pain and suffering," stating, "having regard to the applicant's submissions, [the Court] is of the view that she must have experienced considerable anguish and suffering, including her fears about her physical capacity to take care of another child and to ensure its welfare and happiness, which would not be satisfied by a mere finding of a violation of the [European Convention on Human Rights]."[466]

***K.L. v. Peru* (2005)**

In 2001, K.L., a 17-year-old Peruvian woman carrying a fetus with a fatal anomaly (anencephaly), was denied a therapeutic abortion by Peruvian health officials, despite Peruvian law allowing pregnancy termination for health reasons. K.L. carried the anencephalic fetus to term and gave birth to a baby who died, as was inevitable, several days later.[467] The Human Rights Committee found that compelling a woman to continue a pregnancy that posed risks to her health and life was a violation of the right to be free from torture or cruel, inhuman, or degrading treatment or punishment.[468]

The Committee noted that:

> *owing to the refusal of the medical authorities to carry out the therapeutic abortion, [K.L.] had to endure the distress of seeing her daughter's marked deformities and knowing that she would die very soon. This was an experience which added further pain and distress to that which she had already borne during the period when she was obliged to continue with the pregnancy. . . . The omission on the part of the State in not enabling the author to benefit from a therapeutic abortion was, in the Committee's view, the cause of the suffering she experienced. The Committee has pointed out [that the right to be free from torture and cruel, inhuman, or degrading treatment] relates not only to physical pain but also to mental suffering . . . . Consequently, the Committee considers that the facts before it reveal a violation of [this right].*[469]

***Paulina del Carmen Ramírez Jacinto v. Mexico* (2007)**

Paulina was raped in her home at age fourteen, resulting in a pregnancy. Although she was entitled to a legal abortion under these circumstances, she was ultimately prevented by state authorities from exercising her right to an abortion. Her case, which was brought before the Inter-American Commission on Human Rights and eventually settled, highlights some of the issues at stake in being forced to carry a pregnancy to term.

The settlement provided for damages and compensation for Paulina and her son, including the medical expenses incurred by Paulina as a result of the incident; maintenance expenses and assistance with necessities and school supplies; support for housing expenses; entitlement to state-run health services for both Paulina and her son until he reaches adult age or concludes his higher education; entitlement to state-sponsored psychological care for Paulina and her son; the provision of school fees and supplies for her son each academic year up to the high-school level; start-up funding and technical support to Paulina to help her set up a microenterprise; and payment for moral damages.[470]

The settlement recognizes that bearing and raising a child has a significant financial and personal impact on a woman, affecting access to education and employment opportunities and consequently affecting the ability to pay for health and housing costs. By agreeing to provide Paulina and her son psychological care, the state also recognized the mental health implications for the woman and child from forcing the woman to carry to term a pregnancy conceived from rape.

Obstacles and Barriers to Seeking and Obtaining Post-Abortion Care

Just as women encounter multiple barriers to safe abortion services, women requiring post-abortion care must also overcome a series of obstacles to access care at a healthcare facility and to obtain quality care from the healthcare providers on duty. Hurdles to access include the fear of prosecution and social stigma and the prohibitive costs associated with obtaining post-abortion care. Impediments to quality care range from a lack of trained staff capable of offering post-abortion care, provider reluctance to offer care due to the fear and stigma associated with providing these services, the pervasive solicitation of bribes, negative provider attitudes and related verbal abuse, and inadequate pain management. Although women who seek post-abortion care services may have experienced either spontaneous or induced abortion, this discussion will focus on those women seeking post-abortion care after an induced, and often unsafe, abortion.

Barriers to Seeking Post-Abortion Care

Women who suffer complications from unsafe abortion face multiple barriers to accessing post-abortion care in a healthcare facility. Some women never even attempt to seek care: a recent study conducted in an informal settlement in Nairobi found that the majority of women who died from abortion complications did not seek emergency care in a health facility following an unsafe abortion.[471] The primary factors deterring women from seeking care include fear of prosecution and stigma and prohibitive transportation and medical costs. These factors both deter women from seeking care and delay women from obtaining timely care, increasing their risk of experiencing serious, potentially life-threatening, complications.

Fear of Prosecution Inhibits Women from Seeking Post-Abortion Care

> *When you go to hospital to get care for PAC [post-abortion care], you will be arrested at the hospital for doing abortion. . . . No one can go to the hospital after an abortion.*[472]
>
> ***—Evelyne, Kibera resident whose daughter, Sarah, died after not seeking care following an unsafe abortion***

When asked whether women faced obstacles to obtaining post-abortion care, a nurse who both works at a government facility and operates a private practice in Sindo, a town in Suba District, replied that the law deters and delays women's access to post-abortion care: "Women may not seek post-abortion care because of the restriction from the government. They are afraid of the law. Women delay coming for treatment and then only come when they are worse."[473] A nurse-midwife with a private clinic in Nairobi echoed this sentiment: "There is . . . fear because of the law. That is the main problem. . . . If they come here they are scared because they don't want it to be known that they have gone somewhere else for an abortion."[474] One woman who had delayed seeking post-abortion care explained, "I bled for one week and had discharge. But I didn't go to the doctor before that because I was fearing that the doctor could forward my case [to the legal authorities]. So I sat at home fearing.

When the bleeding stopped and I could see there was some infection, that is when I decided to go."[475] A community organizer in Kibera who works with women who have undergone unsafe abortions was unequivocal: "They fear seeking post-abortion care because they could be arrested."[476]

Although community education and awareness-raising about existing post-abortion care services was a key component of the Ministry of Health's 2002 official standards for management of complications of unsafe abortion,[477] some women remain unaware that post-abortion care is a legal service that should be available at government facilities. A reproductive health coordinator in Suba District confirmed that "women may not seek post-abortion care because of lack of awareness. There is not enough community mobilization or sensitization"[478] about post-abortion care services, leaving women fearful of seeking emergency care. The nurse-manager at Suba District Hospital concurred: "Rarely do women come early enough for post-abortion care. . . . Anyone who has aborted is seen as a criminal. We need to sensitize the community that services can be offered safely."[479]

Even when women do decide to obtain emergency care, their fear of the law presents additional barriers to immediate and effective care. For example, women may not be forthcoming about their medical history. According to a long-practicing nurse-midwife, "that is the biggest challenge as providers. You get the wrong history. They lie about the month of pregnancy. They say they are three months pregnant when they are really six months pregnant,"[480] making appropriate care more difficult to determine and risking the health complications of improper post-abortion care treatment.

Although the government and the Ministry of Health have made clear that post-abortion care "is legal and not punishable by any part of Kenya laws,"[481] this declaration provides explicit legal protection only to providers so that they will feel comfortable offering post-abortion care services. The Ministry of Health's Post Abortion Care Trainer's Manual makes clear that the "provision of comprehensive post abortion care does not lead to punishment or withdrawal of registration of the services provider" and further highlights the ethical and professional responsibilities of providers to offer such care.[482] No mention is made of legal protections for women who seek post-abortion care. The only protection for women is a guarantee that charges will not be pressed against them for obtaining emergency medical care, which is not a crime to begin with—it does nothing to reduce the risk of arrest and prosecution women may face in obtaining such care.

Fear of arrest upon seeking post-abortion care services is not unfounded. A nurse who runs a maternity hospital in Nairobi and who provides post-abortion care stated that "there is a lot of threatening and mistreatment by the police. The police went to a clinic in Eastlands, found women in the waiting room [who were thought to be seeking abortion-related services] and they were all picked up."[483] Similarly, a long-time nurse employee at Coast Provincial General Hospital in Mombasa reported that she had seen women suspected of terminating pregnancies forcibly brought to the hospital by the police:

> *They get a report from the neighbors who say this lady was pregnant and now we are not seeing any pregnancy. So the police bring her to the hospital, she is treated and after she has recovered she is taken to the police station to be tried. These cases . . . [occur] once every three months. The police keep guard over the woman because she might escape so even if she is going to sleep in the ward for three days the police will just be there. . . . When she has been treated and recovered they take her to the police station.*[484]

Such police practices can also create fear among providers of abortion-related services and other women on the same gynecology ward who may also be receiving post-abortion care for both spontaneous and induced abortions.

As mentioned earlier, another woman interviewed by the Center for Reproductive Rights told of a friend who procured an abortion: "She was six months pregnant. After aborting she got very sick and was taken to Kenyatta Hospital. She was a housewife. The husband came . . . with the police and . . . the woman is [now] in jail at Langata Women's Prison."[485] Thus, arrest and trial are a very real consequence of abortion and seeking post-abortion care may serve to make women more vulnerable to prosecution.

Stigma Poses a Barrier to Post-Abortion Care

> *There is 1/3 or 1/2 [of women] that delay coming for [post-abortion care] because of fear . . . they come with sepsis and come after they have bled a lot and they are already anemic and [some of them are] going into shock.*[486]
> ***— Dr. Karanja, Department of OB/GYN, University of Nairobi/Kenyatta National Hospital***

The stigma and fear surrounding abortion is also present in the context of post-abortion care. The Ministry of Health's Post-Abortion Care Trainer's Manual addresses this issue: "For many women, an unintended pregnancy or use of abortion services can lead to social ostracism or rejection by family members. To avoid such rejection, women will often delay seeking care, even to the point of death."[487] Similarly, providers are deterred from offering services or providing referrals because of fear of arrest or community condemnation. This fear of legal repercussions and social censure present a major barrier to post-abortion care services.

In a focus group discussion in Mombasa conducted by the Center for Reproductive Rights, young women told of others they knew who had died from unsafe abortion: "One went to a quack at four months and bled to death. She didn't have the cash to pay for treatment and was ashamed so didn't want to go for treatment—she was a Muslim student and didn't go because of shame,"[488] recounted one participant. Another woman told of a relative who "tried to abort, took a concoction . . . started bleeding, locked herself in her room and when we opened the door she had already died."[489] "Most don't go to a hospital," a focus group participant explained, "they die in the house because of shame."[490] Focus group discussants from Kibera had similar stories: one participant's cousin had suffered complications from an unsafe abortion but refused to go to the hospital. Eventually, the participant explained, "she was pushed by the parents to go . . . . She was ashamed and didn't want to go."[491] The cousin died three days after being admitted to the hospital.[492]

Recrimination from the community can go beyond social ostracism. One focus group participant from Kibera explained that, if the community finds out, "the women who come to help you can be physically abusive before taking you to the hospital."[493] The Ministry of Health's Post-Abortion Care Trainer's Manual explicitly discusses the impact of these negative community attitudes on women's ability to obtain post-abortion care, stating, "This leads to a situation where the community do not empathize with a woman whose life is at risk and do not support or assist her to go to a facility where she can get appropriate life saving services."[494]

Providers interviewed for this report also spoke of the fear of societal reproach that prevents women from seeking post-abortion care in a timely manner. A doctor with a not-for-profit clinic in Kisumu said that, in his experience, "women delay seeking PAC [post-abortion care] because of stigma. They don't want to be identified as doing abortion so they just come as a last resort when they are so sick and have bled so much."[495] An obstetrician-gynecologist consultant at New Nyanza Provincial Hospital concurred: "Women delay care and are hiding because of stigma. . . . They hide until it's almost too late."[496]

These delays can create additional barriers to care, as lower cadres of providers are often not equipped to handle serious complications and may need to refer women to a different facility, resulting in greater costs for care and transport. A nurse in Mbita remarked that, when he used to provide post-abortion care, he would have women coming to him for care a week after obtaining an unsafe abortion "and the infection has already set in and you doing post-abortion care is adding more problems to this person. The uterus is infected and weak and you could perforate the uterus with post-abortion care."[497] Trained only in manual vacuum aspiration (MVA), he had to refer such cases to the nearest gynecologist, of which there are relatively few in Kenya. The gynecologist he referred his clients to was in Homa Bay,[498] a costly and difficult-to-reach location for the majority of Mbita residents who do not have private means of transport.

Women wishing to avoid stigmatization often look for emergency care in facilities far from their residence and surrounding community. They tend to seek emergency care only when they can go far away and do so unseen, a task more difficult for poor women who may not be able to afford transportation or other costs associated with travel. A nurse with a private clinic in an informal settlement in Nairobi observed, "Everyone knows if you've come here to the clinic and wonders what they're doing here and they watch. This scares women. Sometimes we have people coming from far because they want to go somewhere where they are not known."[499] A woman who sought care after an unsafe abortion recounted,

> *I went to a hospital that is very far from this place because I was fearing to go near—some places here have friends and the church. I'm in the choir at church—because this is a shameful issue. And they would know what I've done. So I decided to go far.*[500]

For the same reasons, women also hide their true identity and give providers fake names when coming for treatment, said a member of the Suba District Health Management Team—"they are . . . afraid to have their names recorded and released. There is a fear of stigma and of their family's stigma."[501] For women who cannot afford to travel long distances for healthcare services, stigma can be a formidable obstacle to accessing life-saving emergency care.

Stigma also leads women to seek care in the middle of the night to avoid being observed by members of the community. According to Dr. Joseph Karanja, who teaches at the OB/GYN department of the University of Nairobi/Kenyatta National Hospital (KNH), "Many times you find more [women] come [for post-abortion care] at night than during the day. They know that nights are not as busy as day or maybe they want the cover of darkness."[502] This tactic raises security concerns for women. A community post-abortion care project in Nakuru District found that women "were either harassed or attacked when they traveled routes [to health facilities] at night."[503] The community implemented security measures in response: "chief camps and police posts were developed and placed strategically

along routes to health facilities to allow for the safe passage of women."[504] Another study in two informal settlements in Nairobi found that even though the distance to the referral facilities in the city center were not necessarily far, "accessing facilities at night can be difficult due to rampant insecurity" in these settlements.[505] These risks of violence are yet another obstacle that women face in their efforts to avoid the stigma associated with post-abortion care.

Finally, stigmatizing behavior by public-sector healthcare providers towards post-abortion care clients deters women from seeking post-abortion care at public health facilities in particular. Although Dr. Bartilol Kigen, head of the Ministry of Health's Division of Reproductive Health at the time of the interview, stressed that "there are no attitude issues with healthcare providers,"[506] women and other healthcare providers interviewed by the Center for Reproductive Rights consistently raised the issue of verbal abuse by healthcare workers in the public sector. [See Negative Attitudes and Verbal Abuse, p. 92].[507]

Costs Associated with Post-Abortion Care Prevent Access to Services

The cost of post-abortion care can pose significant obstacles to women's access to care. The price of post-abortion care in Kenya varies greatly, both within and across the private and public health sectors. The fee charged ranges in accordance with the socioeconomic status of the client, the level of public facility, and the cadre of healthcare provider offering the services. It also differs depending on the severity of a woman's complications, as the complexity of the care required and the length of hospital stay affect the cost of services.

As discussed in the regulatory framework section [see Post-Abortion Care: Regulatory Framework Affirms Importance of Providing Services, p. 40], standard post-abortion care in Kenya is a simple MVA procedure accompanied by post-abortion counseling.[508] The prices quoted by private practitioners or public health workers are for these two specific services, and do not include a hospital stay or the additional cost of antibiotics or analgesics. Neither do they include transportation costs in cases where women are referred to another healthcare facility, either due to the severity of their complications or the lack of adequately trained staff in their local health institution. Transportation costs in and of themselves are a significant barrier to post-abortion care access. The Ministry of Health, in its post-abortion care Trainer's Manual, states that "[t]he poor status of the economy has made it impossible for most Kenyans to pay fares for long distances to public hospitals where [post-abortion care-trained] doctors are found in addition to cost sharing that is now expected of them in the health facilities."[509]

Additional costs aside, most women, healthcare administrators, and providers interviewed for this report agreed that the cost of basic post-abortion care services alone was a major deterrent factor for women seeking emergency care following an unsafe abortion. Those interviewed identified both public- and private-sector post-abortion care services as prohibitively expensive for poor women. As discussed earlier, poor women are more likely to need post-abortion care for complications from unsafe abortion since wealthier women tend to have reliable access to safe abortion services and therefore usually do not require such care.[510]

Women living in poverty have often spent any available funds on procuring an abortion or have attempted to induce an abortion on their own—and are suffering the consequences and complications. They may delay seeking post-abortion care because they cannot afford it; when they do seek care, they arrive with greater complications and often face an even heavier financial burden than they

initially feared. In addition, the stigma surrounding abortion prevents women from seeking financial assistance for post-abortion care from their families or communities, as they might do in other medical emergencies.[511]

Public Sector Fees Vary and Discourage Seeking Care

Post-abortion care fees at public health facilities in Kenya range widely, with payment seemingly dependent on the level of facility and its geographical location. According to the reproductive health coordinator for Suba District, the Mbita Subdistrict Hospital charges 300 shillings ($4) for MVA.[512] The same procedure costs 500 shillings ($6.50) at Suba District Hospital,[513] 1,000 shillings ($13) at Kisumu East District Hospital,[514] and 2,500 shillings ($33) at New Nyanza Provincial Hospital in Kisumu, according to an obstetrician-gynecologist consultant at that facility.[515] Comparatively, at Coast Provincial General Hospital in Mombasa, a same-tier facility as New Nyanza Provincial Hospital, post-abortion care costs 1,500 shillings ($20), as reported by a nurse-employee interviewed for this report.[516] The head of KNH's OB/GYN department reported that post-abortion care is "supposed to be 1,000 shillings [$13], unless they're serious and need to be admitted."[517]

These fees are the minimum a woman will pay when seeking post-abortion care. Should she have more severe complications, requiring an extended hospital stay and multiple operations, she will be faced with much higher costs. For example, according to Dr. Karanja, a doctor at Kenyatta National Hospital, one woman from an informal settlement in Nairobi who sought care after an unsafe abortion required two major abdominal surgeries, a stint in the intensive-care unit, and more than eight months' recovery in the hospital ward. Upon eventual discharge from the hospital, her total bill was 250,000 shillings ($3,289). In addition, patients must pay for the drugs they require, such as antibiotics, analgesics, or misoprostol, further adding to the total cost. Dr. Karanja estimated that antibiotics and analgesics add an additional 600 shillings ($8), on average, to the final medical bill.[518]

Although Dr. Kigen claimed that "the fees are not very high for PAC [post-abortion care] services,"[519] according to Dr. Stephen Ochiel, an obstetrician-gynecologist at the University of Nairobi, the "use of public services has gone down because of fees. This prevents women from seeking post-abortion care . . . . The fee is a major barrier to access. Women might not come for services because they can't afford it."[520] The medical superintendent of Kisumu East District Hospital, the former medical superintendent at Coast Provincial General Hospital, and the head of the OB/GYN department at KNH, all agreed that the cost of post-abortion care can be a major obstacle for women requiring such emergency care.[521]

The mere existence of these fees is complicated by the dearth of transparency surrounding them. Many of the fixed fees for basic services in public health facilities—such as the price of delivery services, for example—are listed on a large Ministry of Health-sponsored sign, often posted at the entrance of the facility. None of the public health facilities visited for this report listed a post-abortion care fee on their sign.

This lack of transparency also permits corruption to flourish, further adding to the financial burden experienced by women seeking post-abortion care. [See Bribes Solicited to Receive Post-Abortion Care, p. 90]. Focus group discussions with women in Mombasa,[522] Kibera,[523] and Mbita[524] in Nyanza Province, conducted by the Center for Reproductive Rights, revealed that bribes for post-abortion care services were perceived as common, with the precise amount paid in bribes unknown—"it's secret,"

agreed the women from Mbita.[525] This unpredictable additional cost may also deter women in need of post-abortion care who fear that the bribes demanded for such a stigmatized service will be far more than they can afford.

In addition, the lack of a uniform fee structure for all public health facilities, evident in the dramatic fee differences even between same-level health facilities, also creates public confusion about the cost of services. Many of the women interviewed for this report expressed a similar vague understanding of post-abortion care costs. According to a woman from a focus group discussion in Kibera, "We don't know how much PAC [post-abortion care] costs but it's expensive."[526] A nurse at Coast General Provincial Hospital explained that "women may not come for PAC [post-abortion care] because of lack of money. They think it's going to be costly. When they come and hear it's just 1,500 [$20] they are surprised."[527] Although many women are unable to afford even the 1,500 shilling ($20) fee, the lack of publicly accessible information about post-abortion care fees creates additional barriers to access.

The women interviewed for the report appeared unaware that a fee-waiver system exists in most public health facilities for those who are unable to afford the cost of services such as post-abortion care. Dr. Akula reinforced this proposition, asserting that "ignorance . . . that the fee can be waived" prevents women from seeking post-abortion care.[528] Nearly all of the public health providers interviewed, in contrast, mentioned the possibility of a fee waiver.[529]

Private-Sector Fees can be Arbitrary and Vary Widely

Although women tend to seek emergency post-abortion care services in public health facilities, many women go to private providers as well. As with the cost of abortion services, private practitioners have wide discretion in setting prices for post-abortion care. The private practitioners interviewed for this report charged fees for basic post-abortion care services ranging from 200 shillings ($2.60)[530] and 500 shillings ($6.50)[531] in two small clinics in Mbita to up to more than 5,000 shillings ($66) in a larger Nairobi-based clinic.[532] Prices varied both within towns or cities and between locations throughout Kenya, with differences largely dependent on the fees that clientele in the area surrounding the clinic were able to pay. Discrepancies in prices are also attributable to the cadre of healthcare provider offering the service. For example, a nurse operating in a semi-rural area a few hours outside Kisumu said that she charged 500 shillings ($6.50) for post-abortion care,[533] while a doctor at a private clinic in Kisumu, which serves a wealthier clientele, reported that post-abortion care costs between 3–4,000 shillings ($39–53), depending on the severity of the complications.[534] Dr. Jean Kaggia, an obstetrician-gynecologist with a private practice in Nairobi, said, "the price of post-abortion care will depend. What I charge is my personal feeling. It is like a delivery, consultants charge different things. It will depend on who she is and why you're taking her."[535]

The discretionary power of private providers to set rates can cut both ways by either hindering or facilitating access. In rural areas with limited healthcare access, women may have no choice but to seek emergency care from private providers at higher rates than public facility fees. A former divisional coordinator for the Ministry of Health on Mfangano Island said that only two of the island's seven health facilities had trained staff able to offer post-abortion care. Of these two, "one is a private facility, so some can't afford it."[536] A community project to increase access to post-abortion care in Nakuru District had similar findings, concluding that "access to safe PAC [post-abortion care] services is limited by inadequate numbers of trained providers and insufficient equipment at public-sector sites. Though

post-abortion care services are available through a private-sector network of midwives, the majority of the population cannot afford these services."[537]

However, some private providers recognize that they fill a critical gap in emergency service provision, accordingly altering their fees based on what the client can afford. A private clinic in Mombasa waives the 500-shilling ($6.50) fee for women who cannot afford it.[538] This fee is 1,000 shillings ($13) less than what patients are charged at the nearby Provincial Hospital. A nurse with a private clinic in Mbita explained that women find the services difficult to afford: "antibiotics for sepsis are expensive," he said, "and sometimes we waive the charges."[539] A woman from an informal settlement in Nairobi, who obtained post-abortion care from a private provider, said that her sympathetic doctor waived his service fee, although she still had to pay 1,500 shillings ($20) for the prescribed medicine.[540] Another nurse with a private clinic charges the exact same fee for post-abortion care —500 shillings ($6.50)—as the nearby Suba District Hospital.[541] Thus, while the cost of private-sector post-abortion care services may be a barrier for some women, for others it may be a more affordable and preferable alternative to their local public health facility.

FEE WAIVERS AND DETENTION OF PATIENTS IN HEALTHCARE FACILITIES

The cost of services is a serious barrier for women seeking post-abortion care. As discussed earlier, many women with complications from unsafe abortion refrain from seeking emergency healthcare because they have insufficient funds to afford these services and are unaware that a general waiver system is in place in most public hospitals for those who cannot afford the cost of their medical care.[542] This is consistent with findings from a previous report by the Center for Reproductive Rights and the Federation of Women Lawyers—Kenya, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, which documented violations of women's human rights in Kenyan healthcare facilities. Women interviewed for that report said they did not seek certain kinds of reproductive health services "because they could not afford them."[543]

According to Dr. Akula, "if they can't afford it [fees for post-abortion care services], it's waived. A social worker interviews them and then a committee determines whether to waive the fee."[544] Sarah Abuyeka, a nursing officer on the gynecology ward at New Nyanza Provincial Hospital, agreed: "If she can't pay, you waive the fee [for post-abortion care]. The majority can't pay. It's hard to waive the fee but we do it. They always waive the fee at the billing office. . . . They do it for those who you can see are very poor."[545] However, the process is notoriously complex and difficult for most patients to negotiate successfully. Dr. Karanja noted that "all the public hospitals have a fee waiver system but it is very tedious. It is wasteful. Patients go through 10–13 steps before the waiver is through."[546] Abuyeka offered her recommendation for post-abortion care services: "I wish it's made free."[547]

Fee Waivers and Detention of Patients in Healthcare Facilities, continued...

Although research and interviews for *Failure to Deliver* revealed that many obstacles must be overcome before a fee waiver can be obtained and that "the process of obtaining this waiver can be burdensome, demeaning, and dangerous for the health of the client,"[548] the fee-waiver system is nonetheless a critical safety net for poor individuals requiring emergency care such as post-abortion care. Yet, some public facilities and many private facilities decline to adopt such a system and instead simply refuse services to those who cannot afford the fees, denying them life-saving care until they find the money required for an admission fee or services.[549]

Patients may also find themselves detained in healthcare facilities when they are unable to pay their medical bills. The hospital administration detains patients who cannot afford their fees upon discharge, holding them against their will until they find the requisite funds or until it is clear they cannot pay. In addition to holding them accountable for their original hospital fees, explains a newspaper article, "hospitals continue to charge detained patients an average of $5 to $7 a day, so their debt continues to grow like a high-interest credit card balance."[550] The practice of detention has been documented in Pumwani Maternity Hospital, New Nyanza Provincial Hospital, Kenyatta National Hospital (KNH), and many private hospitals.[551] In KNH, the practice of patient detention has been documented as early as 1999.[552]

Several doctors who work at KNH confirmed in interviews for this report that detention of indigent patients occurs regularly and that post-abortion care patients are among those detained. As Dr. Waithaka explained, "The majority of those coming for PAC [post-abortion care] are extremely poor people. If one could have a way of catering for their services it would go a long way in helping them get those services. The way it is currently, they'll come in and be treated but leaving becomes an issue."[553] Women with the most serious complications are often the ones who delayed seeking post-abortion care because of the prohibitive cost. Yet, as a result, they face more serious health issues, higher medical bills, and greater risks of detention—and thus additional fees—upon discharge. Dr. Zahida Qureshi, an obstetrician-gynecologist at KNH, acknowledged,

> *It's a problem with some [post-abortion care] patients. If they come in with sepsis and anemia they will spend many days in the hospital. If they have serious complications this may make it unaffordable. Blood is not easy to*

get so they have to wait a few days. So they are discharged but don't leave the wards. They have to go through a long procedure. It is the hospital administration [that has implemented this policy]. From our point of view it's not fair . . . but the administration thinks it's necessary. Sick patients can't be treated because discharged patients are occupying the ward.[554]

Dr. Waithaka concurred: "It's a common problem that women [requiring post-abortion care services] can't afford the fees if [their complications are] serious."[555] He explained that upon discharge, patients are detained until they can find the means to pay their bills; however, said Waithaka, "if by the end of the week they have not paid, then processes are started to see how to release them because beyond that they become an expense to the hospital."[556]

Dr. Karanja explained the situation similarly, although he did not mention a distinct time frame for release: "Generally in Kenya poverty levels are very high and even 1,000 shillings [$13] [for post-abortion care] is too much for many. Many don't come and those who come some may be unable to pay and they stay in the ward extra days and they are eventually discharged."[557] The "days" or "week-long" estimate of the length of detention is optimistic: a journalist who recently wrote an article on the practice of detention in Kenyan healthcare facilities, including KNH, interviewed women who had been detained for up to six months for failure to pay their medical bills.[558]

According to a nurse with the National Nurses Association of Kenya and based at KNH, there are typically about 30–40 post-abortion care patients on the ward at KNH at one time and approximately 10 of those patients are detained upon discharge.[559] The nurse said that this corresponds with wider hospital detention rates of about 25% of all patients. For each day the discharged patient is detained, she is charged a fee of 450 shillings ($6), he explained, as "a way to provoke the relatives to pay."[560] He said that these patients "stay long," some remaining in the wards for 2–3 months after discharge.[561]

The policy of harassing family members to pay hospital fees may have a particular impact on post-abortion care or abortion patients. Typically, women do not reveal that they are seeking post-abortion care services to family members or friends. If the hospital reveals this information to family members in order to obtain reimbursement, this may incur damaging condemnation and abuse. Alternatively, if the hospital is unable to locate family members,

this may result in longer stays in detention for these women. In addition, with women left at the mercy of their relatives for their release, the detention system may provide an outlet for families or husbands who disapprove of abortion to refuse to pay the fees and leave women in detention.[562]

A nurse at KNH questioned the logic behind the detention policy: "They [the detained patients] take up bed space of new patients—it's a problem—or they share the bed. They are given food and nurses to care for these people—is it cost-effective? But they say if you allow them to go home, nobody pays."[563] Yet, the detention policy is clearly not an effective solution. According to the same nurse, "they stopped waivers [at KNH] and then they accumulated so many people and were affecting now the normal service, and so they had to put [the waiver system] in place again. . . . It was a crisis—people are not going home. . . . The hospital doesn't want this bad publicity, so they started to waive again."[564] He said that the waiver system at KNH was reinstituted in late 2009, in conjunction with a national campaign to encourage Kenyans to join the National Hospital Insurance Fund. However, it remains to be seen how and whether this new policy plays out in practice.

Healthcare providers in public facilities who demand illegal fees for their services—either in the form of bribes or of exponentially higher, "off the record" fees—also take advantage of this practice of detaining patients. A clinical officer at Kisumu East District Hospital told of one case where some clinical officers at the hospital demanded money under the table before treating a post-abortion care patient who was suffering severe complications after drinking "a concoction of drugs and Omo [strong laundry detergent]."[565] The woman "really cried and her relatives didn't have cash."[566] So instead of waiting to provide treatment until after they had been paid, as is their typical practice, the clinical officers treated the woman and then detained her "until the family brought money."[567]

James Mwamu, vice chairman of the Law Society of Kenya, was unequivocal in stating that the practice of detention is illegal: "If someone owes money, there is a procedure for collecting debt, and it's not detaining people. . . . There is no law that allows hospitals to do what they are doing."[568] In fact, the Code of Professional Conduct and Discipline for medical practitioners explicitly states that "it is unethical for doctors or health institutions to detain patients for non-payment of fees. They should resort to legal means to recover the said fees."[569] Njoroge Baiya, a current member of Parliament, has brought this detention practice to the attention of other members of Parliament. He said, "They know very well that these people can never pay those bills. A more humane policy should be developed."[570] Although a number of detained patients were released from several health facilities,

including KNH, in November 2009 as a result of a government directive, it remains unclear whether the practice has been specifically prohibited or eliminated.

Detention is another serious deterrent for women who require post-abortion care. Prolonged detention, aside from constituting a serious human rights violation, may have additional ramifications for women's livelihoods and the welfare of family members dependent on them for survival—often the very reasons a woman may have risked her life to procure an unsafe abortion in the first place.

Barriers to Obtaining Quality Post-Abortion Care

A woman able to overcome the significant financial and social obstacles to seeking post-abortion care can encounter a new set of barriers to obtaining quality post-abortion care at the healthcare facility. Delays in treatment, both deliberate and resource-based, are common. Care may be denied entirely for failure to pay a demanded bribe. When women do finally receive care, the quality of the care is often poor, characterized by verbal abuse from healthcare staff, poorly performed MVA procedures by untrained providers lacking proficiency in MVA use [see Systemic Issues: Why Women Receive Poor Quality Abortion-Related Services, p. 96], and the absence of pain management. Women have few or no avenues for redress for poor treatment received while seeking post-abortion care.

The Ministry of Health's failure to ensure the availability of 24-hour emergency services in healthcare facilities is another factor that heightens the effect of post-abortion care-trained staff shortages on patient care, leaving many patients with no ability to seek emergency care at night and limited access to trained staff during the day. Although the Ministry of Health has made clear that all hospitals, maternities and health centers are expected to be able to offer 24-hour services, the 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) found that only 57% of hospitals, 59% of maternities, and 20% of health centers have the basic components to support such services.[571] Significantly, only 11% of all government-managed facilities have the basic components to support 24-hour emergency services.[572]

Delays in Providing Care and Denials of Care are Common

Although the government's Post-Abortion Care Trainer's Manual emphasizes that "the prompt treatment of postabortion complications is an important part of healthcare that should be available at every district level hospital" and in all primary health institutions,[573] women often experience delays in receiving post-abortion care at public health facilities. These delays may be structural, resulting from a lack of adequate provider training and supplies; they may be the product of the stigma and criminality surrounding abortion, causing providers to decline to offer services for fear of being seen as complicit in illegally performing an abortion by providing post-abortion care; or they may be deliberate, caused by providers' negative attitudes towards women seeking post-abortion care or by healthcare workers' solicitation of bribes before providing treatment.

Lack of Trained Staff to Perform Services Hinders Care

> *At the end of the day, the government staff is not giving quality services because they are not trained. When it comes to [post-abortion care] people are incapacitated knowledge-wise. We refer clients to those who are trained but they are not always easy to access.[The clients] have to pay for their own transport and may not go.*[574]
>
> ***— Felix Oiki, Suba District Health Management Team, Nyanza Province***

The limited number of healthcare providers trained in post-abortion care was identified by many of those interviewed for this report as a distinct barrier to women's access to care. This was a concern primarily with respect to lower cadres of providers, such as nurses and clinical officers; doctors are generally adequately trained in post-abortion care during medical school. Insufficient numbers of trained clinical officers and nurses means that rural or underserved populations, and lower-level

facilities, are disproportionately affected by these capacity limitations. Immediate and efficient access to post-abortion care is particularly important because it is an emergency service; as stated in the government's Post-Abortion Care Trainer's Manual, post-abortion care is "often essential to save a woman's life and preserve health."[575] Waiting for trained staff to arrive at a facility causes dangerous delays in healthcare provision, and referrals to other facilities or providers often cause both delays and additional financial or logistical barriers to care. The dearth of trained providers was a concern among both public- and private-sector health workers.

A clinical officer who practices at Kisumu East District Hospital discussed the delays in care caused by a lack of trained staff:

> *We have insufficient staff and equipment for abortion. We don't want to raise the issue because it would be controversial. . . . We have only ten trained clinical officers and five trained doctors in MVA. There are times when a woman comes in and no one is there who is trained in PAC [post-abortion care].*[576]

Dr. Akula affirmed that "it happens that sometimes when a woman comes in for post-abortion care there is no trained staff and there is a delay in care."[577] Of the 180 staff eligible to be trained at the Kisumu East District Hospital, he explained, only 10 or so of them are trained in post-abortion care.[578] Similarly, said a former healthcare administrator on Mfangano Island, of the 17 healthcare providers on the island, only 2 of them (a clinical officer and a nurse) are trained in post-abortion care.[579] They serve a population of over 20,000 people.[580] Christine Ong'ete, reproductive health coordinator for Suba District, reports that only 20 providers in the district are trained in post-abortion care, leaving only 10 of the district's 42 government facilities capable of offering MVA services.[581] Dr. Mitei of New Nyanza Provincial Hospital in Kisumu, along with a nurse at Coast Provincial General Hospital in Mombasa, also reported that trainings of hospital staff on post-abortion care are inadequate.[582]

Insufficient training was an issue raised by private-sector providers as well.[583] This was a concern particularly for private practitioners operating in rural or underserved areas where access to higher-level government facilities is limited. One private-sector nurse interviewed for this report operates a small clinic in Mbita. He observed that "there is a need for more training because the ones who are trained are not enough."[584] He himself is not trained in post-abortion care and must refer these cases to other providers—but he worried that "limited means of transportation makes the referral system difficult."[585]

The pervasive lack of training is due largely to the failure to comprehensively incorporate MVA and post-abortion care training into clinical officer and nursing school curriculums and to the dearth of universally accessible professional training programs that would allow providers to learn these skills on the job. The lack of government resources and political will, poor policy implementation and prescriptions, and prohibitive training costs for private providers all contribute to these training deficiencies.

Recognizing that adequate post-abortion care training among nurses and clinical officers was a severe obstacle to quality service provision, the Ministry of Health drafted a National Reproductive Health Curriculum for Service Providers in 2006 to harmonize and standardize the various curricula used in pre and in-service training.[586] The curriculum contains a unit on post-abortion care and is meant to apply to all reproductive health service providers in Kenya, explicitly including clinical officers

and nurses.[587] However, implementation of the policy has been poor leading not only to continuing confusion over nurses' scope of practice, as documented above, but also to a failure to update existing curricula to comply with its requirements. According to the curriculum, the content of the post-abortion care unit includes "performing the MVA procedure," and managing complications and pain during MVA procedure.[588] However, it is clear from the Center for Reproductive Rights' interviews that both clinical officers and nurses are not learning these skills, which is particularly problematic because some government health centers are staffed entirely by nurses and clinical officers, with no doctor employed.

Stigma and Fear Pervade Provision of Services

Stigma and fear around abortion and post-abortion care can discourage providers from offering post-abortion care and, sometimes, from referring clients to those who do. Some private providers may decline to offer services at all, despite having undergone additional in-service training in post-abortion care, because they do not want to be associated with a stigmatized procedure. As one post-abortion care trainer explained, "just because they're trained, doesn't mean providers accept the idea of post-abortion care or safe abortion. So some are trained but don't use MVA kits they are given free of charge. You can see this when you follow up a year later."[589]

Providers also fear that the community or police will harass them for offering services, accusing them of being complicit in procuring the woman's abortion as opposed to offering post-abortion care. [See Beyond the Impact on Women: Providers and the Healthcare System, p. 117]. Faith Mbehero, program officer at the National Nurses Association of Kenya, described how fear of police and community harassment was a major deterrent to trained nurses offering post-abortion care. She noted, "We did follow up studies on why nurses weren't practicing PAC [post-abortion care] after training and they said they were afraid . . . . They were being attacked by communities and the police didn't understand . . . . When [the police] come to the facility they find forceps and then accuse them of procuring abortion."[590] Mbehero commented that providers are reluctant even to fill out the post-abortion care register because they feel intimidated by government inspection teams who accuse them of inducing abortions, rather than acknowledge that they are providing emergency services to women who have already tried to terminate a pregnancy.[591]

Delays in seeking care, often because of fear and stigma, further complicate the picture. Mbehero explained that nurses were concerned that "the women would come to their facility only when they are badly off and about to die and [the nurses] didn't want to be held responsible for their deaths and for inducing their abortion."[592] A private nurse in Nairobi, arrested for allegedly providing abortion services, said that the providers in her clinic take precautions to protect themselves and simply refer all complicated cases. She noted, "Some of them [post-abortion care cases] are so severe we don't attend to them. We prefer to refer them to Kenyatta National Hospital. When they come with sepsis it's hard to treat them and it's hard to say it's not you that did this to the client, so better to refer."[593] This referral practice delays care and creates additional transportation costs for women.

Bribes Solicited to Receive Post-Abortion Care

The stigma and illegality associated with abortion, and thus with post-abortion care, facilitates yet another barrier to post-abortion care: the pervasive solicitation of bribes by healthcare providers. Women interviewed for this report consistently raised bribery as an obstacle to—and requirement for—obtaining care. In a focus group discussion with young women in Kibera, the participants agreed when one woman said, "The public hospitals will definitely ask for bribes [when providing post-abortion

care]. They will threaten to turn you into the police unless you pay them."[594] At another focus group discussion with 19 young women in Mombasa, the consensus was:

> *People charge money on top because it's illegal. If you want them to take care of you immediately, you need to pay a bribe in a government hospital, otherwise they'll take you to the ward and leave you there all day. You bribe them so they don't call the police too.*[595]

Public healthcare workers interviewed for this report substantiated reports of post-abortion care-related extortion. According to a clinical officer, employed for over two years at Kisumu East District Hospital, bribes are a major barrier for women in need of post-abortion care:

> *Anyone who goes for anything to the district hospital has to pay a bribe. . . . When it comes to complications [of abortion] you have to pay more. A clinical officer says to the woman: 'if you don't pay this, we'll leave you to die.' They leave you there but [the women] always pay in the end.*[596]

According to this clinical officer, a woman seeking post-abortion care may be charged up to 15,000 shillings ($197) by corrupt clinicians—in stark contrast to the hospital's official post-abortion care fee of 1,000 shillings ($13).[597] He emphasized that "this money all goes to clinicians," not the hospital.[598]

Bribery is made easier by the stigma and fear associated with abortion and post-abortion care. As discussed above, many women, desperate to avoid being seen by others—either out of fear of arrest or social condemnation—deliberately seek emergency care at night,[599] leaving them more susceptible to extortion by a reduced night-staff with limited accountability. A nurse at Suba District Hospital reported that "some employees here at [Suba District] hospital charge under the table for PAC [post-abortion care]."[600] The women pay these additional costs, she explained, because "they are afraid of the law. . . . Because of restriction of the law, the woman doesn't want to be seen. . . . She will pay more for PAC to do it secretly, in the middle of the night."[601] A nurse-manager at Suba District Hospital told of coming across hospital employees with a patient who required emergency post-abortion care while doing 2 a.m. rounds: "They wanted her to pay under the table and pay first. I happened to be there in the nick of time and came to say you do MVA first and ask for money later. The patient had been waiting for over one hour while they were debating how much she should pay."[602] The nurse explained that when the procedure is done under the table in this manner, it often costs 3,000–4,000 shillings ($39–53)—significantly more than the official price of 500 shillings ($6.50).[603]

The insufficient number of post-abortion care-trained staff in public health facilities also provides another opportunity for corruption to flourish. A clinical officer at Kisumu East District Hospital told of his experience at that government facility:

> *There are times when a woman comes in and no one is there who is trained in PAC [post-abortion care]. . . . The woman needs a connection [to a provider in order to get PAC services] or the nurse must call someone for her. The woman must pay the nurse for the [phone] number of the clinician and then when the clinician comes [to the hospital] then she has to pay the clinician extra. Even if she is bleeding or dying, you have to pay.*[604]

The lack of trained staff gives post-abortion care-trained providers tremendous bargaining power, permitting them to demand bribes for their emergency care services. Other providers are also able to exploit women's desperation by charging them for contacting these trained providers.

Cruel and Degrading Treatment Characterizes Provision of Care

In addition to barriers to obtaining services, women who seek post-abortion care may face additional obstacles to receiving quality and humane medical care. The stigma surrounding abortion in Kenya plays out in the negative attitudes of providers, which often takes the form of verbal abuse, and in the deliberate failure of healthcare providers to provide appropriate pain management during the procedure.

Negative Attitudes and Verbal Abuse

Providers' negative attitudes about post-abortion care were consistently identified by women and providers as a widespread problem in public health facilities, manifesting itself in mistreatment from the withholding of care to verbal abuse. This type of behavior deters women from seeking post-abortion care and can cause devastating delays in treatment. Women with fewer resources are more likely to have unsafe abortions and require post-abortion care [see Poverty: A Contributing Factor in Unwanted Pregnancies and Unsafe Abortion, p. 52] and are therefore disproportionately affected by this behavior.

Such abuse occurs regardless of whether post-abortion care patients have had a spontaneous or induced abortion. A nurse manager of Suba District Hospital observed:

> *The ones who may need services may prefer not to come to the hospital. The attitude of the staff is wanting. They treat any patient, even if miscarriage naturally occurred, as criminal. Patients are reluctant to come because they don't want to be abused. The reception of patients is wanting. Attitudes need to change. Any abortion [spontaneous or induced] is treated as criminal until proven otherwise.*[605]

One woman in a focus group discussion facilitated by the Center for Reproductive Rights in Nairobi described the experience of her sister, at a large referral hospital in 2000, when she went in to be treated for a spontaneous miscarriage.[606] The hospital staff was convinced that she had undergone an abortion and refused to treat her until she would "admit" that she had tried to terminate the pregnancy. The staff wrote in her medical chart that she had received an abortion, which caused serious problems with her husband. She later died of related complications.[607]

A focus group participant in Mombasa observed that "if you go to a government hospital [for post-abortion care], the nurses would harass you. They would say, 'You asked for it.'. . . The government will tell you to go back to where you got the abortion. They will not treat you right away."[608] The Ministry of Health's Post-Abortion Care Trainer's Manual also notes the "mistreatment of women needing care because they are regarded as criminals."[609] In the same manual, the Ministry of Health explicitly acknowledges that women may experience delays in receiving post-abortion care because of negative provider attitudes:

> *If the woman manages to somehow reach the health facility, the service providers often do not take immediate and appropriate action. In some instances, patients may*

be kept waiting two or more days from the time they get to the facility to the time they get emergency care. . . . There is therefore need to train the service providers . . . to make their attitude more supportive.[610]

When care is provided, it is sometimes accompanied by verbal abuse. A clinical officer at Kisumu East District Hospital typically sees his post-abortion care patients after they have seen a nurse. In his experience, "nurses are so abusive in their language. They say, 'You had sex, you had your excitement. Now you're crying, who will help you? We will just leave you to die.'"[611] The nurses never actually turn patients away, the clinical officer clarified, but they do "talk badly."[612] As a result, he noted, most of the patients who experience such verbal abuse do not come back for follow-up care.[613]

A nurse at Suba District Hospital confirmed, "People are verbally abusive if they think you've induced. They say, 'Why didn't you do family planning? Abortion is murder. What you did is wrong.'"[614] Mbehero agreed that "most still have attitudes of stigmatization. They will give the right treatment but they may relate to them differently [if they think it's induced].The approach and way they receive them, they won't be very receptive. . . . It's more verbal abuse, talking to them rudely."[615]

Dr. Waithaka said that such behavior has been addressed at KNH largely through education and policy interventions, but that "in other hospitals outside of here, people still have that mentality and will criminalize the client, which then puts stigma on it and makes those people not come to the hospital early."[616] In an interview with education officers at the Nursing Council of Kenya, the importance of distinguishing between termination and post-abortion care to eliminate patterns of verbal abuse was stressed: "[Nurses] need to see PAC [post-abortion care] as something different that is not an illegal activity but a form of care. . . . People need some education. We know that people procure abortions in a very crude manner. But if you were to dissociate the termination from the process or care that you receive once you've done this, that would be good. This is not really emphasized in nursing school."[617]

Inadequate Pain Management

According to the World Health Organization's (WHO) technical guidelines, one of the basic elements of emergency resuscitation, which "should be available without delay wherever women initially seek [post-abortion care] care," is pain control.[618] This can include analgesics, the administration of a paracervical block, and sedation with a minor tranquillizer such as diazepam.[619] The WHO's clinical management guidelines state that "[m]any women having abortion complications suffer pain and need prompt and effective medication for their pain. To select appropriate pain control, one must consider the conditions present, the timing and the route of administration, and the precautions for each type of pain control."[620] When performing MVA, the WHO recommends the use of "[m]ild sedation, analgesia, and/or local anaesthesia."[621] The Kenyan government's Post-Abortion Care Trainer's Manual likewise notes that since a woman is awake during MVA, "clinicians must be very attentive to the management of pain through supportive interaction and proper medication and gentle operative technique. While each health facility needs an overall protocol for pain control medication, the individual provider must respond to the individual particular needs of each woman treated."[622]

However, studies and interviews reveal that women in Kenya seeking post-abortion care receive little or no pain management. A 2004 study conducted by Ipas and the Ministry of Health on unsafe abortion in Kenya found that "a large proportion of women who may have rightly deserved administration of pain relief agents were not provided with any pain management."[623] These findings are consistent with

a 2005 study in Kenyan hospitals, which found that "although MVA was used to treat 80% of first trimester incomplete abortion cases, analgesia was used in only 30% of these cases."[624] Further, the study cited previous research in Kenya that found that "only 3% of women undergoing MVA and 44% of those who had sharp curettage received pain medication [and] almost all of the women reported experiencing pain during their procedure, with 60% describing the pain as 'extreme'."[625]

Although the vast majority of Kenyan healthcare facilities have the capacity to offer anesthesia, some providers interviewed for this report noted that they, or their colleagues, typically did not use anesthesia during the MVA procedure.[626] One medical practitioner claimed it was not recommended,[627] while a clinical officer at Kisumu East District Hospital explained that he doesn't use anesthesia because "anesthesia is a rarity in a government hospital."[628] However, the 2004 KSPAS found that 90% of health facilities—and 91% of government managed facilities—in Kenya have an anesthesia-giving set. In addition, 82% of government facilities have an anesthetist on staff.[629] Analgesics are also widely available in Kenyan healthcare facilities.[630]

This incongruity between capacity and practice is a product of both a lack of adequate training and poor attitudes towards post-abortion care patients among some healthcare providers.[631] According to one Kenyan reproductive health expert and post-abortion care trainer, some trainers may not always offer comprehensive post-abortion care training; instead, they simply show providers how to use the MVA kit without teaching them how to care for it or how to appropriately attend to pain management.[632] For example, according to Dr. Akula, "in most cases, PAC [post-abortion care] is done without anesthesia. The training given is that most clients can tolerate pain, it's minimal pain."[633]

A reproductive health specialist and MVA trainer in Kenya disagreed with this assessment:

> *Patients have rights and according to me if you're going to do MVA without pain care it is an assault on the person. You're not treating them, it's like assaulting them physically which is very wrong and unethical. We make them know [trainees] that this is a painful procedure and we have a means of controlling that pain and it should be given. . . . So if you have a health facility where they don't have pain killers—there should be analgesics and local anesthetics in place.*[634]

Dr. Waithaka stated that the training and teaching hospital at the University of Nairobi/KNH has only recently begun comprehensively training students to give local anesthesia during post-abortion care.[635] According to a Kenyan reproductive health expert, medical students at the University of Nairobi have traditionally not been trained on how to do a paracervical block, although this has now been added to the curriculum. [636] Dr. Karanja explained that "most people are not using pain management because they haven't been taught. In the past it was just verbocaine—verbal talk" as pain management.[637] Current protocol at KNH, said Karanja, is to use an analgesic and those with the skills also use a paracervical block when appropriate.[638]

Provider attitudes towards women in general, and those seeking post-abortion care, also shape the provision of pain management. A 2005 study on the magnitude of abortion complications in Kenya found that "[s]ome health care providers do not give appropriate attention to pain management . . . due [in part] to negative attitudes toward women who they suspect of having had induced abortion. . . ."[639] Providers interviewed for this report also pointed to negative stereotypes and financial concerns to explain the deliberate withholding of pain care. "It's very common that a provider would purposefully withhold pain killers," recounted a reproductive health expert and post-abortion care

trainer. "There is a belief that African women are strong and that they don't feel pain. We hear this very commonly."[640]

In addition, patients are reluctant to speak up for themselves. "Our people sometimes feel that the health system is doing them a favor by providing care—they feel pain and they try to bear it and feel that someone is doing a favor for them" said the post-abortion care trainer.[641] Dr. Karanja concurred, saying that even at KNH there are doctors who do not provide any pain care.[642] According to Dr. Karanja, it is not a question of being unaware that the procedure may be painful: "The patients feel pain, they scream. They should use something."[643] He explained that some nonetheless withhold pain care intentionally because, perhaps for financial or logistical reasons, "they just didn't want to give sedations and analgesics so the hospital stay is not increased."[644]

Limited or No Redress for Abortion-Related Abuses

There are few avenues for redress for women who experience abuses during the provision of abortion-related healthcare services. As with denials of access to a legal abortion [see Few Avenues for Redress, p. 64], the obstacles to redress stem from the lack of meaningful or effective complaints mechanisms for patients,[645] both within individual healthcare facilities and at the national level among professional regulatory bodies such as the Medical Practitioners and Dentists Board (Medical Board).

In addition, women may be deterred from reporting abuses or filing civil complaints for fear of exposing themselves to potential prosecution for having procured an "illegal" abortion. One such example is a woman whose uterus was removed, without her consent, during an abortion procedure. In an interview for this report, an official with close ties to the Medical Board explained that the woman brought a complaint before the Board; the provider, upon being questioned by the Board about the case, said that whatever wrong he committed, the woman also had done something unlawful and therefore she should be prosecuted as well. The woman dropped the case.[646]

Providers are also left without meaningful recourse in such cases. Dr. Qureshi told of one doctor she had worked with in a previous hospital who had performed an unsafe abortion on a woman in his home; the woman had come into the hospital afterwards with post-abortion complications. The woman was 18 years old and had to have a hysterectomy. Dr. Qureshi explained, "We took this case up with the hospital administration and they had an inquiry. He didn't get fired, just got transferred. It was very sad."[647] Dr. Qureshi further noted, "There is no way of reporting people who do bad abortions to the MPDB [Medical Board].There is no reporting mechanism, no official way to report."[648]

The criminalization of abortion permits providers to act with impunity in the provision of abortion and post-abortion care services, leaving women little choice but to suffer through verbal abuse and violations of their physical integrity at the hands of their healthcare providers.

Systemic Issues: Why Women Receive Poor Quality Abortion-Related Services

The Kenyan public healthcare system is poorly equipped to handle the high rates of unsafe abortion cases presenting in government facilities. Due to a combination of a lack of resources, failure to prioritize training and equipment for post-abortion care and abortion services, limited guidance from the government about what the law permits and who can offer services, and the stigma and fear stemming from the criminalization of abortion, post-abortion care and abortion services do not meet the population's needs. Christine Ong'ete, reproductive health coordinator for Suba District, described the current state of affairs in her district:

> *We don't really have enough information to handle abortion cases. We only have a few facilities with trained personnel and kits/supplies. Some of the people trained have been transferred or left their jobs for NGOs [non-governmental organizations]. We have asked the [Ministry of Health] for support, but the government usually claims there are not enough funds and we have very few partner NGOs supporting PAC [post-abortion care] services. Currently we have no partner supporting these services [in Suba District].*[649]

Although the Ministry of Health claims that post-abortion care is a priority area for the government and has made improvement of post-abortion care a key component of its current national reproductive health strategy,[650] it has not devoted the resources, attention, or institutional support to strengthening post-abortion care services to reflect that fact.

Access to abortion-related services is further hindered by a lack of clarity concerning clinical officers' and nurses' scope of practice in Kenya. There are mixed signals from professional regulatory bodies, academic institutions and training instructors, and the Ministry of Health on whether these two cadres of healthcare providers are permitted to offer safe abortion services; nurses are additionally uncertain as to whether they may offer post-abortion care. This confusion complicates effective service provision and is particularly problematic as these providers have the greatest geographical and population reach of all the healthcare providers in Kenya and are often on the front lines of service provision in rural or underserved areas.

Clinical Methods Used for Abortion and Post-Abortion Care

The World Health Organization's (WHO) Safe Abortion Guidelines state the following as "Preferred Methods of Abortion:" [651]

- For up to 12 completed weeks since last menstrual period:
  - "The preferred methods are manual or electric vacuum aspiration, or medical methods using a combination of mifepristone followed by a prostaglandin."
  - "Dilatation and curettage (D&C) should be used only where none of the above methods are available."
- For after 12 completed weeks since last menstrual period:
  - "The preferred medical method . . . is mifespristone followed by repeated doses of a prostaglandin such as misoprostol."
  - "The preferred surgical method is dilatation and evacuation (D&E), using vacuum aspiration and forceps."

Manual/Electric Vacuum Aspiration (MVA/EVA):
"A surgical technique for abortion during early pregnancy in which the contents of the uterus are evacuated through a plastic or metal cannula which is attached to a manual or electric vacuum source."[652] The technique can also be used for management of incomplete abortion.[653] According to the WHO, "MVA is a simple, cost-effective procedure . . . [that] is highly effective in removing retained products of conception from the uterus and is associated with a low complication rate. It is an effective method of treatment for uterine sizes up to 12 weeks LMP (i.e. 12 weeks from the first day of the last menstrual period). MVA does not require a general anaesthetic and can be performed in an examination or procedure room, rather than in an operating room."[654]

Dilation and Curettage (D&C):
A method that "involves dilating the cervix through use of mechanical dilators or pharmacological agents and using sharp metal curettes to scrape the walls of the uterus, removing its contents."[655] According to the WHO, "[t]he use of D&C requires operating theatre facilities and staff trained in surgical techniques and general anaesthesia. Vacuum Aspiration is generally preferred to D&C due to the lower complications rate and reduced need for surgical facilities."[656] The WHO also notes that "[i]n many parts of the world, [D&C] has been replaced by vacuum aspiration which is safer and less traumatic if equipment is available and well maintained."[657]

Dilation and Evacuation (D&E):
"A surgical technique used in second-trimester abortions in which the uterus is evacuated with suction curettage and forceps."[658]

Medical Abortion:
"The use of pharmacological agents [i.e., medicines as opposed to a surgical procedure], singly or in combination, to induce abortion."[659] According to Ipas, "[t]he most effective medicines for inducing abortion are mifepristone and misoprostol used in combination. Where mifepristone is not available, misoprostol used on its own is also effective."[660] Misoprostol can also be used in post-abortion care to "treat incomplete abortion or miscarriage."[661]

Nurses and Clinical Officers: An Underutilized Resource in Addressing Unsafe Abortion

Clinical Officers: Issues with Training and Scope of Practice

> *The abortion mandate is on the doctors, and possibly the clinical officers.*[662]
>
> ***— Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Health, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Health***

> *I wish I'd had more training in clinical officers school. I only know MVA and only the theoretical part. We were not given the opportunity to do the practical part in school.*[663]
>
> ***— Clinical Officer, Kisumu East District Hospital***

According to the Kenya Medical Training College, which trains the majority of clinical officers in Kenya, clinical officers are "middle level health personnels who offer a wide range of medical services—curative, preventive, promotive and rehabilitative—in all parts of the country. The [clinical officers] supplement the work of medical doctors at all levels of healthcare—from health centers (where they are in charge), district and provincial hospitals to referral teaching hospitals."[664]

Clinical officers train in medicine for three years, usually in a teaching hospital, and then do a one-year internship before they qualify for registration. Unlike doctors, training for clinical officers is conducted at the diploma level and lasts for four, as opposed to six, years. After completing their initial training, clinical officers can pursue an 18-month higher diploma to specialize in a particular medical field.[665] With respect to maternal healthcare, the 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) explains that "[a]lthough clinical officers have less obstetric training than doctors, some of them provide obstetric care on a regular basis."[666]

According to the chief and deputy chief clinical officers at the Ministry of Medical Services, Micah Kisoo and Manaseh Bocha, clinical officers "have the highest patient contact hours. . . . Eighty percent of patients in the country are seen by clinical officers first in Kenya."[667] Kisoo and Bocha explained that there is currently a shortage of clinical officers at all levels of healthcare facilities and, as such, "clinical officers are overwhelmed by the number of patients. They can see one hundred patients per day."[668] In particular, they explained, "when it comes to the field work, then most of the work is for the clinical officers—they [as opposed to the doctors] have most of the patients in the field."[669] According to the 2004 KSPAS, there are almost 5,000 clinical officers in Kenya, with about 16 clinical officers per 100,000 people; these numbers are roughly the same as those for doctors in Kenya.[670]

Shortcomings in Post-Abortion Care Training

Unlike nurses, clinical officers are required to learn post-abortion care during their medical training, as clearly documented in the clinical officer reproductive health curriculum.[671] Kisoo, who is also the registrar for the Clinical Officers Council—the statutory body charged with overseeing the training, registration, and licensing of clinical officers—and Bocha both noted that clinical officers were trained in post-abortion care.[672] However, the degree to which clinical officers are skilled in MVA provision is in question. Sylverns Ater Kagose of Suba District Hospital argued:

> *Clinical officers say they've been trained at college but what you see here shows that they have not been trained. . . . The clinical officers are unqualified. . . . The problem is that some of the patients may not be getting the best service they require and when required because of the untrained personnel. I have had to repeat MVAs because they were done wrong. The attitude of the staff—they want to do MVA to get money and not to help the patient and in the end they do an incomplete job. The first person [women] come into contact with is clinical officers [and] they say they were trained in PAC [post-abortion care] in college but weren't. Now I won't let the clinical officers use the MVA without my supervision.*[673]

Dr. Aggrey Akula, medical superintendent of Kisumu East District Hospital, also noted that clinical officers are not always well trained: "Training is relative—some are trained but proficiency is lacking. . . . It is one thing to be trained and another to be proficient."[674]

The discrepancy in training and competency appears to stem from the manner in which the material is currently taught to clinical officers. Although they are supposed to learn both the theory and practice of post-abortion care, at present, the practical, hands-on component of the MVA procedure is not always taught.[675] Kisoo and Bocha recognized that "there are some gaps in the curriculum" and "are trying to review it to make it more hands on."[676] Rather than simply observing the procedure, "we want them to conduct at least ten MVAs" in the course of their training, explained Kisoo and Bocha.[677] They attributed the current gap to a lack of resources and insufficient number of mentors or teachers on the ward:

> *Right now [in the curriculum] we have theory and are supposed to do practice for PAC [post-abortion care], but when you come to the supervisory bit it is difficult—[the clinical officers] are just spectators not doing practice. They are supposed to do something tangible, they need to be practicing. But we don't have enough supervisors because of the economy. Because of the demand and [low] number of tutors it becomes a challenge. Students are also lacking clinical preceptors—people to mentor the students. Lecturers just tell them to go to the ward but no one is assigned specifically to mentor the students.*[678]

Finally, although Kisoo and Bocha asserted that clinical officers are taught to do family planning counseling after post-abortion care,[679] it is not explicitly listed in the reproductive health component of their curriculum,[680] and one clinical officer, asked about whether he does post-abortion family planning counseling, responded that it is "a nursing thing."[681]

Lack of Clarity on Role in Providing Abortion Services

Upon entering the workforce and being expected to cover gaps in healthcare service provision, clinical officers trained in MVA may be uncertain about whether they are formally or legally permitted to provide terminations. Interviews with Kisoo and Bocha suggest that "clinical officers would never do a termination. They would only do post-abortion care."[682] They explained, "It's not that they're not capable, but we don't want them to run into problems of interpretation of the law. If it was legal, they would be trained in termination."[683] Kisoo and Bocha admitted that although clinical officers possess the skills and capabilities to perform abortions, "it's better to refer because we don't want them to get into trouble. . . . It's good to be safe and do what is comfortable within your limits. Refer, or if you

can do it, fine."[684] These conflicting messages deter many potentially qualified clinical officers from providing terminations, preventing women in areas where there are no gynecologists or doctors from accessing safe and legal abortion services.

In addition, some clinical officers lack the complete set of skills necessary to provide a safe abortion.[685] Educated primarily in theory rather than practice, clinical officers' training may not include the procedural techniques and clinical skills necessary to perform quality abortion—or even post-abortion care —procedures. Further, a lack of training on medical abortion or other abortion techniques, such as dilation and evacuation (D&E), leaves clinical officers able to perform only MVA. As a result, some clinical officers might do MVA past the 12 weeks gestational cut-off for safe MVA performance[686] or "at all stages [of a pregnancy because] this is the only possibility."[687] A 2004 study on unsafe abortion in Kenya found that "[d]espite the contraindication of using MVA for treating complications beyond the first trimester, MVA (with or without analgesia) was performed for 72% of second-trimester cases requiring evacuation."[688]

However, some clinical officers undergo additional reproductive health training in school, or receive on-the-job training on abortion and post-abortion care through continuing education programs, and are undeniably qualified to provide termination services. In such cases, clinical officers are concerned about the potential repercussions of offering abortion services without formal professional protections, such as the protections offered to doctors by the Medical Practitioners and Dentists Board's Code of Professional Conduct and Discipline. Dr. Joseph Karanja, an obstetrician-gynecologist who teaches at the OB/GYN department at the University of Nairobi/Kenyatta National Hospital (KNH), noted that "clinical officers and nursing councils could address [this gap], but they are not progressive with termination and wouldn't take the initiative to issue guidelines."[689]

The uncertainty and lack of clarity among clinical officers as to their official scope of practice creates tremendous barriers for women who qualify for legal termination and are unable to access a doctor's services. If clinical officers were formally trained in termination and made aware of their authority to do so, the number of healthcare providers capable of offering safe and legal terminations in Kenya would instantly double from 5,000 to 10,000.[690]

Nurses: Issues with Training and Scope of Practice Regarding Post-Abortion Care

The Center for Reproductive Rights' interviews with nurses, educational officers at the Nursing Council of Kenya, lecturers at the University of Nairobi's School of Nursing Sciences (School of Nursing), the program officer at the National Nurses Association of Kenya (NNAK), and the head of the Ministry of Health's Division of Reproductive Health illustrate the lack of clarity within the nursing profession about whether post-abortion care, specifically the MVA procedure, is considered part of nurses' official scope of practice.

According to the Nursing Council, charged with overseeing the curriculum for all registered nurses, nurses are responsible for diagnosing and counseling post-abortion care patients—"invasive procedures" like post-abortion care are not included in the curriculum and nurses are neither formally taught MVA procedures nor required to know how to do MVA in order to graduate.[691] "MVA is considered a procedure for medical officers," explained David Wambuku and Frederick Ochieno of the Nursing Council; if nurses come across post-abortion care clients in their practice, they generally provide the patient with antibiotics and refer her to the nearest medical officer.[692]

However, Wambuku and Ochieno conceded that although MVA is not within nurses' scope of practice, "similar to male circumcision, nurses do it but the law is silent on it."[693] They further stated that they "agree that the syllabus is deficient in PAC [post-abortion care]" but explained that in order to change the curriculum to include MVA, the Nursing Council would have to reexamine the nursing scope of practice and determine whether the procedure qualifies for inclusion.[694]

The School of Nursing substantiates this understanding of nurses' scope of practice: all four School of Nursing lecturers interviewed for this report asserted that nurses are not allowed to perform invasive procedures such as MVA.[695] Instead, the lecturers explained, nurses are taught exclusively abortion counseling and diagnosis. In fact, the school's staff itself is largely not trained on MVA and therefore cannot teach the procedure to students—the staff do not even have the equipment to demonstrate the procedure within the nursing school.[696]

At the same time, these lecturers recognized that nongovernmental organizations (NGOs) are teaching post-abortion care /MVA to nurses as part of on-the-job training. The lecturers further acknowledged that if nurses are interested in learning the procedure, they can do so on the wards while in school if they find a doctor willing to teach them.[697] As one lecturer put it, "Nurses are not taught how to do MVA. But if they go to the ward and find a doctor willing to teach them [they may learn the procedure]. It depends on the nurses' interest once they are on the wards in KNH."[698] They also agreed that "nurses can be allowed to get MVA skills" and acknowledged that nurses are receiving mixed signals, with one lecturer explaining that the "Nursing Council has said do and don't—nurses don't do invasive procedures but of late nurses are taught MVA."[699] As one lecturer concluded, and the others agreed, "now [nurses] are allowed to do [MVA]. The Nursing Council in collaboration with the Ministry of Health allowed this possibility."[700]

Dr. Bartilol Kigen, head of the Ministry of Health's Division of Reproductive Health at the time of the interview, contended that "in terms of PAC [post-abortion care], we are allowing everyone to do it. PAC is part of the new nursing curriculum."[701] This position is consistent with the Ministry of Health's Second National Health Sector Strategic Plan for Kenya: Norms and Standards for Health Service Delivery, which requires that a registered comprehensive nurse who can provide post-abortion care be available at all level-two facilities,[702] and the Ministry's National Reproductive Health Curriculum for Service Providers, which applies to nurses, clinical officers, and doctors and includes a unit on MVA training.[703] However, according to the Nursing Council, although the Division of Reproductive Health was "instrumental in helping the Nursing Council to revise the nursing school syllabus" in 2008, MVA was not added to the document.[704] Further, Wambuku and Ochieno asserted that "there has never been a person outside [of the Nursing Council] interested in nurses learning about PAC [post-abortion care] as a competence to be acquired or as a prerequisite to be licensed."[705]

Understanding varies widely within the nursing community on whether post-abortion care falls within nurses' scope of practice. According to a nurse who conducts post-abortion care trainings, "nurses have . . . been allowed to do PAC [post-abortion care] since 1990. Otherwise it was the doctor's domain. . . . [Trainers] use the PAC curriculum by the MOH [Ministry of Health] for all providers."[706] However, a Ministry of Health employee in Suba District said that post-abortion care training for nurses did not occur before 2003.[707] A program officer at NNAK said that "in public institutions, nurses think [post-abortion care] is outside the scope of their work and isn't compensated."[708]

Dr. Akula said that nurses receive conflicting directives and are justifiably hesitant to offer post-abortion care services. He contended that

> *nurses were doing [post-abortion care] but had to stop because they are not allowed to do certain procedures. The Nursing Council doesn't allow them to do this. So the Nursing Council gives a directive that they should not carry out procedures they are not intended to do because they are not protected. This was a year or two ago. Some still do it but at their own risk. They were doing it and then they stopped because of the Nursing Council.*[709]

Dr. Akula acknowledged that there is a new reproductive health policy from the Ministry of Health that allows nurses to be trained in post-abortion care "but there are mixed signals because the policy has not been disseminated. It was launched but widespread dissemination has not been done."[710]

As a result of this uncertainty, nurses are sometimes faced with a distinct ethical and professional dilemma. One lecturer at the School of Nursing captured the concern:

> *Nurses may know what to do, and the doctor is not available, but because of the restriction of the division of labor she can't assist. . . . So you find yourself in a situation where you are doing things you're not supposed to do and if you don't someone will die. If you are in the hospital or dispensary alone, with no doctor to refer to, you will try to do something. It's an ethical dilemma.*[711]

However, nurses' adherence to their perceived scope of practice often depends on the reality they face on the ground. "It depends," said Mbehero of NNAK, "if you go to KNH which is a high-level referral [hospital], they will not do [post-abortion care] because there are doctors there to do it. But in district hospitals they will do it because there is no other option."[712] Training nurses would increase the trained post-abortion care staff in Kenya more than eight-fold, when compared to training doctors alone—according to World Health Organization (WHO) statistics released in 2009, Kenya has 4,506 physicians and 37,113 nursing and midwifery personnel.[713]

The issue of nurses providing termination services is even murkier. Although the "good faith clause" in the Penal Code [see Kenya's Abortion Law and Polices, p. 32] simply states that a "person" may perform a termination to save a woman's life and does not specify professional qualifications,[714] nurses, unlike doctors, are not protected by a professional regulatory framework that explicitly recognizes their ability to provide abortion services under certain conditions. As a NNAK representative explained, "if something goes wrong, who will cover the nurses? There is no law that covers them. So they would rather not get involved at all."[715]

Shortcomings in Abortion-Related Counseling

Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally.[716]

— Former Special Rapporteur on the Right to Health

Abortion-related counseling often falls to nursing staff, although it is not exclusively their responsibility, said Faith Mbehero of NNAK.[717] Clinical officers are not currently being trained in either abortion or post-abortion counseling, said Manaseh Bocha, deputy chief clinical officer at the Ministry of Medical Services.[718] However, it is unclear what kind of training on abortion-related counseling nurses are receiving, if any.

According to nurses in the educational department at the Nursing Council of Kenya, "nurses are taught general counseling, not specific to abortion. They are taught specific family planning knowledge, but abortion-specific counseling is not taught. Abortion has not been seen as a method of family planning in Kenya."[719] In contrast, Dr. Blasio Omuga, lecturer in obstetrics and midwifery at the School of Nursing, asserts that nurses *are* being taught how to conduct abortion-related counseling;[720] however, the content of what is taught does not appear to be based entirely on evidence-based treatment. Dr. Omuga explained that nurses are taught to discuss the "long-term psychological trauma of terminating by choice" and to make women "aware of the long-term psychological stress [associated with termination] and how counseling can help them."[721] According to a comprehensive, scientific review of published studies examining the mental health implications of induced abortion, "[t]he best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."[722]

In addition, nurses are often unfamiliar with the abortion law and may believe abortion to be illegal in all circumstances. According to lecturers at the School of Nursing in Nairobi, the school has not included the National Guidelines on the Medical Management of Rape/Sexual Violence (Sexual Violence Guidelines) in its curriculum and it does not explicitly teach nurses that the guidelines specify that abortion is an option in such circumstances—leaving most nurses unaware that this is something that should be discussed with women who have become pregnant from rape.[723] Instead, explained

a School of Nursing lecturer, "In the case of a woman who is raped and then becomes pregnant . . . [nursing students] are taught that there are two options: first try to convince them to keep the pregnancy and give the baby away or keep it; if that doesn't work then they are taught to say that they [the nurses] need to have a consultation with [a doctor or doctors—typically a gynecologist and a psychiatrist]."[724] Thus, the counseling priority appears to be a focus on reconciling women with the reality of their pregnancy and perhaps suggesting that adoption may be an option after the child is born. Finally, the verbal abuse documented in the earlier sections on fear and stigma [see Women Encounter Provider Stigma and Abuse, p. 63; Negative Attitudes and Verbal Abuse, p. 92] suggests that further sensitization on how to conduct appropriate abortion-related counseling is needed.

The same paucity of appropriate training applies to community health workers who, because of their work on HIV/AIDS or other reproductive health issues, end up counseling women on abortion. One such worker, who counsels people living with HIV, many of whom are survivors of sexual violence, explained, "We are not trained in abortion counseling. We just talk to them generally. We [tell them] . . . that abortion may lead to death . . . and . . . to infections and other diseases. Also it is not according to God's will. Biblically it is not accepted. . . . We just say what we know from our own experience."[725] Recognizing the need for comprehensive training on abortion counseling and the Sexual Violence Guidelines, this community health worker submitted a training proposal to the government in 2008. She has yet to receive a response.[726]

Training Gaps: Reasons and Consequences

Although Dr. Kigen of the Division of Reproductive Health said that post-abortion care training is "a priority area for us," he also acknowledged the insufficient numbers of post-abortion care-trained providers.[727] He noted that "there are a lot of issues about capacity. You keep training and there is a lot of turnover; [there is] also the exit of providers from the Ministry to elsewhere."[728] In the year prior to the 2004 KSPAS, for example, only 5% of all service providers interviewed reported receiving in-service training on post-abortion care.[729] As a comparison, 25% of service providers reported receiving in-service training on preventing mother-to-child transmission of HIV[730] and 58% participated in a training course related to HIV/AIDS[731] in the 12 months preceding the survey.

Dr. Kigen asserted that when providers "request it, there is support for training."[732] However, some providers disagree. A nurse and head of a small maternity hospital in Nairobi felt that the government is not really doing enough training on post-abortion care.[733] In addition, Felix Oiki of the Suba District Health Management Team asserted:

The government is not funding training on PAC [post-abortion care]. They will do IMCI [Integrated Management of Childhood Illnesses] training but not PAC. It depends on the government's priorities and this is not a current government priority. All seventeen providers on Mfangano Island have had IMCI training, for example [while only two are trained in PAC].[734]

The lack of political will on the part of government is coupled with, and perhaps results in, a lack of resources for on-the-job training. As Dr. Karanja explained, "in-service training is expensive. It takes people away from the services, so it's not easy to cover countrywide. . ."[735] Ong'ete, reproductive health coordinator for Suba District, explained that the trainings in Suba District have all been done by an NGO. "The government doesn't fund the training or provide MVA kits. . . . The government goes through partners to support training. . . . There is a lack of funds so they go through partners."[736] Dr. Akula said that only a little more than five percent of his staff is trained in post-abortion care "because of lack of resources and . . . staff being relocated after being trained."[737]

Further, when the Ministry of Health does support and promote post-abortion care trainings, the trainings focus nearly exclusively on first-trimester abortion complications, which can be managed with the use of an MVA kit.[738] Very few providers in Kenya are trained to offer second-trimester abortions or post-abortion care, which cannot be performed using an MVA kit and require additional training in other abortion techniques.[739] Dr. Karanja explained that only gynecology residents learn how to perform a second-trimester abortion via a D&E procedure or the use of misoprostol; they typically learn these skills from other hospital staff while on the job.[740]

In rural areas, where there are only clinical officers and nurses on duty in many health facilities, second-trimester abortions or abortion complications must be referred to the nearest district hospital. Even then, many of these district hospitals do not have gynecologists on staff. According to Dr. Karanja, "maybe 75% of gynecologists are in the big towns. Most women don't have access [to abortion-related services] for the second trimester."[741] Dr. Joachim Osur, a Kenyan reproductive health specialist, concurred with Dr. Karanja's assessment: currently only gynecologists are trained to safely and competently provide second-trimester abortion services in Kenya. He noted that "second-trimester abortions cause the highest morbidity because not many centers are able to provide care [post-abortion care]. . . . One only hopes that a referral center is close by" for women in need of these services.[742]

Shortcomings in Government-Issued Guidance on Providing Safe Abortion and Post-Abortion Care

The Ministry of Health has stated its institutional commitment to improving and increasing access to post-abortion care services, and to ensuring "that women have access to safe abortion to the full extent of the law."[743] In 2004, Dr. James Nyikal, then director of medical services at the Ministry, declared that the Ministry would "make efforts to ensure that . . . health providers are aware and knowledgeable about policies and service guidelines and standards as recommend in the latest World Health Organization (WHO) guidelines. . . ."[744] However, serious shortcomings still persist in the area of government-issued guidance on providing safe abortion and post-abortion care.

Interviews with providers revealed confusion around the existence of government-issued technical guidelines on post-abortion care. When asked whether they were aware of or used any post-abortion care guidelines in their work, healthcare providers responded with a range of answers. One clinical

officer interviewed stated that "there are no guidelines on [post-abortion care]."[745] Some providers, like Sarah Abuyeka of New Nyanza Provincial Hospital, said that the guidelines were unnecessary: "We had a manual but we know it already so don't need it. We know what we are supposed to do so there is no manual here [for PAC]."[746] Others, such as Oiki of Suba District Health Management Team, said that "the [post-abortion care] guidelines are there but then you find they are not being used."[747] Mbehero of NNAK found that "people are not well-equipped on what the government guidelines are."[748]

Based on interviews and visits to the Division of Reproductive Health, the Center for Reproductive Rights was unable to identify service provision guidelines focused solely on abortion or post-abortion care.[749] Dr. Karanja, who has a long history of working closely with the Division of Reproductive Health on drafting clinical guidelines in the area of reproductive health, has stated unequivocally that there are no such guidelines.[750] The Ministry of Health's Essential Obstetric Care Manual: For Health Service Providers in Kenya does include a section on abortion and post-abortion care[751] but it is unclear the extent to which this publication is disseminated. Rather than providing guidelines for service providers, the Ministry of Health and its Division of Reproductive Health appear to have focused almost exclusively on creating training manuals. When asked why that would be the case, Dr. Karanja commented, "There should be guidelines then a trainer's manual. I don't know why that happened."[752]

The few training resources that do exist are not particularly user-friendly. For example, the government's Post-Abortion Care Trainer's Manual is impractical for trainer purposes. Dr. Akula, who is a post-abortion care trainer, said the trainer manual is too "voluminous," and trainers don't have the time required to use them when doing on-the-job training at the hospital.[753] "We are supposed to use them for on-the-job training but the guidelines are too long and we don't have time, so we just show them how to do it practically. . . . They should be summarized," said Akula.[754] The trainee's manual is also a sizeable handbook and not necessarily an easy reference tool for providers as they go about their work.[755] Significantly, neither the nurses nor clinical officers interviewed for this report seemed to have much exposure to the trainee's manual.

The National Reproductive Health Curriculum for Service Providers, which includes a unit on post-abortion care and was created in an effort to standardize the reproductive health curriculum for all reproductive health service providers in Kenya, was also not practically designed to suit the context in which it is meant to be used. The training is designed, in part, for in-service use for those already working in the field, yet—according to Kenyan reproductive health specialist Dr. Osur—requires six consecutive months in order to be completed. As Dr. Osur explained, "A hospital cannot release you for six months to go and do reproductive health. And it's expensive. So I don't know how much implementation is taking place."[756]

Lack of Necessary Supplies and Equipment

Even when a provider who is trained and willing to offer post-abortion care services is available, lack of equipment and supplies may nonetheless still delay care and impair its quality.

Overall Capacity Issues: Basic Emergency Obstetric Care

In general, the Kenyan healthcare system is not equipped to deal with the high rates of unsafe abortion cases presenting at its healthcare facilities. According to the 2004 KSPAS, only 9% of hospitals, maternities, and health centers have the capacity to provide basic emergency obstetric care.[757] When

disaggregated by province, only 7% of facilities in the Rift Valley Province were capable of offering basic services, despite having by far the largest population of any province in Kenya.[758] Only 6% of hospitals, maternities, and health centers in Kenya were found to offer comprehensive emergency obstetric services.[759]

Although the Ministry of Health has made clear that all hospitals, maternities, and health centers are expected to be able to offer 24-hour services, the 2004 KSPAS found that only 57% of hospitals, 59% of maternities, and 20% of health centers have the basic components to support such services.[760] Only 11% of all government-managed facilities have the basic components to support 24-hour emergency services.[761] Kenyan healthcare facilities often lack basic equipment necessary for the provision of post-abortion care and safe abortion, including clean latex gloves, soap, water, disinfecting solution, sterilization equipment, and the MVA equipment itself.

Basic Supplies: Water and Gloves

Running water, for example, is critical both during the provision of post-abortion care —often the women presenting are hemorrhaging blood, and water is critical to their care and management— and for cleaning the MVA equipment after use in post-abortion care or safe abortion. According to Ipas, a well-known MVA manufacturer and distributor,[762] the MVA kit's aspirators and adapters must be soaked immediately after use and then cleaned thoroughly in warm water and detergent.[763] However, the 2004 KSPAS found that only 25% of government facilities have a regular water supply.[764] Consistent with these findings, Abuyeka of New Nyanza Provincial Hospital mentioned the lack of regular running water as one of the main challenges to providing post-abortion care in her facility.[765]

Further, clean latex gloves are particularly important for a procedure involving blood and bodily fluids. Although 94% of facilities were found by the 2004 KSPAS to have clean latex gloves in the delivery service area, this number varied by facility and only 81% of maternities had gloves in the delivery service area.[766] Despite these statistics, Mbehero of NNAK says that "in the public-sector it is bad— sometimes there are no gloves in public hospitals."[767] This is especially critical in the post-abortion care context because providers are reluctant to treat patients who are hemorrhaging, as post-abortion care patients often are. A community post-abortion care project in Nakuru found that "due to the high prevalence of HIV, many people had been hesitant to touch women who were bleeding."[768] Providing gloves to providers, the project found, gave them "more confidence to deal with women who are bleeding and in need of help."[769]

Blood Supplies

Adequate blood supplies, which are critical in cases of severe complications and loss of blood following an unsafe abortion,[770] are often in short supply in Kenya's public health facilities. Abuyeka cited insufficient blood supplies as a major obstacle to post-abortion care provision: "A patient may come bleeding so much and there is no blood to transfer. The blood is not there in the blood bank."[771] According to the 2004 KSPAS, only 11% of government facilities and only 20% of health facilities overall offer blood transfusion services. In contrast, 47% of private for-profit facilities offer such services.[772]

Inconsistent availability of blood in Kenya's blood banks may delay care and increase hospital fees for post-abortion care patients.[773] Dr. Zahida Qureshi, a professor of OB/GYN at the University of Nairobi/ KNH, explained that one reason fees can be prohibitively high for some women seeking post-abortion

care is because "blood is not easy to get so [women] have to wait a few days," thereby delaying their care and increasing their hospital bill.[774] This delay in receiving blood may be particularly true for post-abortion care patients. According to a 2002 comprehensive study on the blood transfusion system in Kenya, "the most frequent source [of blood] is donations from relatives or friends"; alternatively, family members sometimes "make private arrangements with individuals who donate blood for some payment."[775] However, many women seek post-abortion care without the support of friends and family, eliminating this potential source of blood donation.

Problems with Availability and Quality of MVA Equipment for Abortion and Post-Abortion Care

Although MVA equipment is on the government's essential supplies list, survey data and interviews with healthcare providers indicate that Kenya faces a severe shortage of MVA equipment in its public healthcare system. Given that most abortions in Kenya are performed using an MVA kit and that post-abortion care often requires vacuum aspiration, this presents a serious concern for the availability and timely provision of abortion services. In some public hospitals, for example, despite the presence of trained staff, MVA cannot be performed because the kits are unavailable. If safe abortion services are to be offered in this context, practitioners, the majority of whom are trained only in MVA,[776] must learn dilation and curettage (D&C) on the job.[777]

According to providers interviewed for this report, the severe equipment shortage is a result of the government's failure to ensure the regular procurement and distribution of MVA kits, either due to a lack of resources or poor management and procurement skills. The government's failure to ensure that providers are adequately trained to use the kits further limits the available supply, as inadequately trained providers sometimes mishandle and irreparably damage kits that are not then replaced by the Ministry of Health.

Shortages of MVA Equipment

The 2004 KSPAS presents a snapshot of Kenya's capacity to provide first-trimester abortions and post-abortion care. The survey found a pervasive lack of MVA equipment throughout the healthcare system, severely limiting the system's ability to provide abortion and post-abortion care services. According to the 2004 KSPAS, among all facilities that offer delivery services in Kenya, only 16% have a vacuum aspirator and only 14% have a D&C kit.[778] Private, for-profit facilities were most equipped, with 32% of such facilities equipped with a vacuum aspirator and 36% with a D&C kit.[779] Government facilities were far less prepared, with only 14% in possession of a vacuum aspirator and 7% equipped with a D&C kit.[780]

Forty-two percent of hospitals and maternities possessed the capacity to remove retained products of conception with a vacuum aspirator.[781] In contrast, of all health centers, clinics, and dispensaries in Kenya, 8%, 16% and 0% of each facility level, respectively, had the capacity to provide MVA services.[782] Finally, the ability to provide abortion services ranged widely according to geographical location. [783]

A 2009 study assessed the "quality of emergency obstetric services available to women in two typical Nairobi slums, Korogocho and Viwandani."[784] Of the 25 health facilities studied within or near the two slums, only 8 facilities had MVAs available and "some of the reported equipment were not in working condition or locked up somewhere."[785] Only 9% of the skilled healthcare workers could perform MVA

and 16% D&C.[786] The study also found that "only 5 health facilities had emergency transport on site for referral of obstetric emergencies," leaving 56% of emergency patients "to arrive at referral hospitals on foot or public transport."[787] In addition, a 2005 survey funded by USAID found that in Kenya, access to treatment for abortion complications varied widely between urban and rural residents.[788] This outcome is consistent with the 2004 KSPAS's findings on the limited capacity of lower-level facilities with greater rural reach, such as clinics and health centers, to provide MVA services.

The 2004 KSPAS and USAID survey findings correlate with the information gathered from provider interviews in 2009: many providers, both private and public, expressed concern at the lack of MVA equipment. Although the Ministry of Health's Implementation Plan for the National Reproductive Health Strategy: 1999-2003, which was confirmed to still be in effect as of November 2009, provided for five MVA kits and three D&C sets to be issued to each of 100 hospitals across the country,[789] the current MVA equipment supply in hospitals remains insufficient for the volume of post-abortion care patients being served.[790] Entire districts don't have MVA kits, noted one reproductive health specialist.[791] According to one practicing nurse at Coast Provincial General Hospital in Mombasa, the lack of supplies is particularly acute in rural areas.[792]

The shortage is most severe in the public health sector, which Dr. Karanja attributed to the fact that "[f]or a long time the government wasn't buying MVA kits . . ."[793] Public health providers interviewed for this report consistently mentioned the challenges of limited MVA equipment. A nurse employed at Suba District Hospital reported that the hospital has only one MVA kit, which is not enough to deal with the number of patients they receive.[794] Similarly, Dr. Akula noted that one challenge in providing timely post-abortion care services is the limited number of MVA kits;[795] a clinical officer interviewed at the same hospital concurred.[796] According to Dr. Akula, the Ministry of Health supplies them with equipment only "once in a blue moon" which is insufficient for the hospital's caseload and presents obstacles to the effective provision of post-abortion care.[797]

Abuyeka explained that New Nyanza Provincial Hospital had one aspirator machine for the entire ward and no MVA kits; if the electric vacuum aspirator is not functioning, they are unable to treat women who require post-abortion care immediately.[798] Dr. Mitei, an OB/GYN consultant at the same hospital, agreed: "sometimes [the machine] breaks and we need MVA kits as back up, which we don't have now."[799] The School of Nursing has no MVA kits at all,[800] despite the fact that the Ministry of Health has issued a strategic plan for the health sector requiring nurses to be trained in post-abortion care.[801]

The reason for the dearth in MVA kits in public facilities, according to Christine Ong'ete, reproductive health coordinator for Suba District, is that the government lacks the financial resources to provide kits.[802] Dr. Kigen, head of the Division of Reproductive Health at the time of the interview, asserted that "we make sure there are supplies for the provision of PAC [post-abortion care] services, [like] MVA kits" but acknowledges that a challenge for the Ministry "is the supply of the kits [at the different levels of healthcare facilities]. Do all the facilities have the capacity to do the MVAs up to Level 2? Some don't have it. Levels 3–5 have the MVA kits. If they request more equipment we try to supply it."[803] However, some public hospitals are reluctant to request the necessary supplies for MVA because they don't want to be seen as providing illegal services. As a clinical officer at Kisumu District Hospital explained, "We have insufficient staff and equipment for abortion [but we] don't want to raise the issue because it would be controversial."[804]

The lack of sufficient MVA equipment also appears to be a function of management deficiencies and poor procurement efforts on the part of the Ministry of Health. According to providers interviewed for this report, several years ago, after placing MVA kits on its essential supplies list, the government purchased substandard MVA kits for its central stores.[805] According to Dr. Osur, they "could not be used, they were just a mess, and had to be thrown away. . . . The people who received them, the information we got is that they couldn't use them."[806] Providers are not clear why the government chose to buy these substandard kits.[807] According to Dr. Osur, the head of the Division of Reproductive Health at the time simply said that it was "a problem with procurement."[808]

Monica Oguttu of the Kisumu Medical and Educational Trust (KMET) has a similar account of poor government procurement, explaining that, a few years ago, the government purchased MVA kits but bought single- instead of double-valve kits, "which are not useful for incomplete abortion."[809] According to Oguttu, the government has not purchased MVA kits for its central stores since that time and, in Western and Nyanza Provinces, district hospitals just buy directly from KMET instead.[810] Oguttu asserted that "for MVA kits it's only KMET distributing in all of Western Kenya."[811] She attributed the lack of supplies to the Ministry of Health's low prioritization of reproductive health issues, explaining, "the location of funds for reproductive health issues are not there. It looks like everything else is budgeted for except the reproductive health supplies. Contraceptives are erratically supplied and maybe MVA is not budgeted for and it's not in their supplies."[812]

Within the last few years, the government has taken the initiative to place MVA kits on its essential supplies list, allowing hospitals to place an order for the equipment directly from their own budget, thereby ostensibly improving access to this equipment. Thus, despite the fact that the government does not appear to have taken the initiative to stock kits after the faulty equipment incident, hospitals can circumvent this limitation by ordering kits from another source, using their own funds, thereby eliminating obstacles to obtaining equipment presented by the national government.[813] It remains to be seen whether this will improve equipment stocks in district hospitals. Dr. Qureshi noted that although KNH is also a public facility, "there are an abundance of supplies here, this is not a problem. [This is because KNH is] . . . separate from the MOH [Ministry of Health]. It has its own board and manages itself. We don't get our supplies from the MOH."[814]

Private providers interviewed for this report also complained of a lack of sufficient MVA equipment as a barrier to providing post-abortion care. The reason given for limited supplies was primarily cost. "MVA instruments are quite expensive," explained a nurse in a medium-sized private clinic in Nairobi.[815] Said the nurse, ". . . at one time the government gave them out for post-abortion care, but no longer."[816] A double-valve MVA kit from KMET, for example, costs 4,800 shillings ($63).[817]

Expensive equipment means that small-scale clinics serving relatively remote populations with limited access to healthcare are unable to offer services. A nurse trained in post-abortion care who runs his own small clinic in Mbita, without any additional service staff, said that post-abortion care equipment is prohibitively expensive and he was unable to buy a new kit. He recommended that the "cost of [post-abortion care] instruments . . . be relatively affordable so a growing clinic like mine can afford [to have an MVA kit]."[818]

Frequent Breakdowns of MVA Kits

In addition to cost and lack of government funding and distribution, both public and private providers attributed the insufficient number of MVA kits to the fact that kits were repeatedly breaking down.[819] At New Nyanza Provincial Hospital, which has an electric vacuum aspirator, Abuyeka recalled, "we used to have MVA kits but they broke up and we were given the machine from the store."[820] However, they still do not have back up MVAs in stock for when the electric machine breaks down.[821]

Experts and practitioners attribute the breakdown in kits to a lack of sufficient training.[822] Although some providers may be trained in how to use the kit, they do not receive comprehensive training on how to clean and care for it. Others simply use the kits "without any formal training."[823] For example, Dr. Akula attributes the frequent breakdowns to the lack of clinical officer and intern training on how to use the MVA kits: "we have to keep buying them because they [providers] are not well trained. . . . Now we have three functional kits. We had six but they are breaking down."[824] Kagose of Suba District Hospital agreed that employees' lack of post-abortion care training means that unqualified providers are using the equipment and "they damage the MVA kit."[825]

One reproductive health specialist said that he has seen providers perform MVA procedures without knowing how to use the kit and that sometimes it is necessary "to go and redo a full training because people are not sure how to use it."[826] The problem became clear after he observed a provider trying to do an MVA who "broke three kits in one go. So we arranged to do a new set of trainings."[827] Not only does this lack of training have a considerable impact on the availability of supplies—but to endure repeated attempts to perform an MVA procedure makes worse an already traumatic situation for women. As Dr. Osur stated, "One wonders what the quality of care would be in such situations . . ."[828]

Oguttu of KMET said that high staff turnover in government facilities, combined with predominantly on-the-job—and thus time-constrained and not always comprehensive—training in MVA use, results in staff being ill-equipped to deal with disassembling and assembling the kits for sterilizing and cleaning.[829] Often, it is the valves and plungers that break during this process.[830] Oguttu explained, "the lifespan of the kit depends on the care. You might know how to use it but not how to take care of it." She asserted that "most of the ones [providers] who break the kits learn on the job." In response to this issue, KMET has begun collaboration with the coordinators of the continuing medical education department in order to incorporate kit maintenance and care into provider trainings.[831]

Dr. Karanja agreed that the frequent breakdowns of MVA kits can be attributed to "a lack of training in its use and maintenance and in handling and care of the kit."[832] In particular, he pointed to a "lack of experience in how to dismantle and clean and assemble the kit."[833] Providers are not adequately trained on the importance of lubricating the kit; Karanja explained, "if you don't lubricate [the kit it] can break within a week."[834] Even at KNH, where students are trained in kit maintenance, there are problems with ensuring kit longevity. Karanja said, "we teach them this [maintenance] here but maybe the time is not enough. But at least they are better than people who never learned."[835]

Sometimes kit breakage can simply be attributed to the fact that the kit has multiple small components that can easily be lost in a large and busy hospital setting. According to Karanja, "even in our unit they keep losing the collar stop—it looks as if it is nothing. Someone not familiar might think it is something that came from a package or something. It's a small plastic ring that is lost easily."[836]

Limited Infection Control and MVA Equipment

Health facilities often face dual problems of a limited ability to sterilize equipment and control infection coupled with an insufficient supply of vacuum aspiration equipment, creating a high risk of infection and delaying the provision of care.

Infection control is critical in all healthcare contexts, particularly with equipment such as an MVA kit that comes into contact with blood and bodily fluids and is reused multiple times on different patients. The equipment must be thoroughly cleaned and sterilized between uses to prevent transmission of infection: an inability to sterilize the kit may result in delays or denials of care or in poor quality care for patients. For MVA kits, this means cleaning in warm water and detergent, followed by high-level disinfection or sterilization of the kit between every patient.[837]

However, the capacity for infection control is limited in Kenyan healthcare facilities: 54% of government facilities do not have all the necessary items for infection control in the delivery service area, defined by the 2004 KSPAS as soap, water, sharps box, disinfecting solution, and clean latex gloves.[838] The private sector is similarly ill-equipped, with 52% of private-sector facilities, 84% of NGO-run facilities, and 73% faith-based facilities lacking the capacity for full infection control, leaving the overall capacity for infection control in Kenya's healthcare system at 40%.[839] In fact, only 27% of government facilities have equipment for sterilization and only 1% of government facilities have the capacity to perform chemical high-level disinfecting.[840] In addition, only 20% of government facilities have written guidelines for sterilization procedures.[841]

Reproductive health specialist Dr. Osur is unequivocal on the importance of training and technical guidance on cleaning and sterilizing MVA kits. A lack of training can lead to infection transmission, including HIV infection, from patient to patient—"those who have not been trained can be dangerous. They can really be dangerous," said Osur.[842] Limited MVA kits means that kits are constantly being reused; each kit must be sterilized between uses, further delaying care. A private nurse in Mbita recounted that he had only a single MVA kit when he used to provide post-abortion care. It had to be sterilized between each use and "you could get a patient when the MVA was not sterilized yet and couldn't serve the client."[843] Some providers, in an attempt to offer immediate care, choose not to sterilize the kit between uses or may not do as thorough a job as required, exposing women to a higher probability of infections and prolonged complications. A private nurse in a Nairobi clinic explained, "one kit is for ten patients so there are risks of infections."[844]

Lack of Public Health Data on Unsafe Abortion

> *Our documentation of PAC [post-abortion care] clients is also a challenge. Sometimes we don't have really good documentation and records that come to us are not good. Especially in the facilities it's not usually very good and we find we really can't say that services are well provided.*[845]
>
> ***— Dr. Meme and Dr. Gituto, Division of Reproductive Health***

The fear, stigma and illegality associated with abortion impedes comprehensive and accurate documentation on the number of women seeking abortion and post-abortion care services. The WHO notes that "[m]ore than any other aspect of sexual and reproductive ill-health, abortion suffers from gross under-reporting."[846] As with other countries with restrictive abortion laws, existing data on the

magnitude of unsafe abortion in Kenya and the number of induced abortions per year in Kenya is likely a significant underestimate, and of limited value to policymakers seeking to understand the impact of unsafe abortion on the public healthcare system and to make informed decisions regarding resource allocation and public health priorities.

The government, say some healthcare providers, is partly responsible for this phenomenon of underreporting. According to Mbehero of NNAK, providers deliberately underreport the number of post-abortion care cases they see "because they don't want to be accused [by the police or government inspection teams] of inducing instead of just providing post-abortion care."[847] Although providers are given a government-issued post-abortion care register to fill out, they "feel intimidated filling out a PAC [post-abortion care] register" and "feel pressure to hide the right information for their own security," explained Mbehero.[848] This is because they have experienced visits from government health inspection teams who question whether the post-abortion care cases recorded in their registers were induced or were genuine cases of post-abortion care.[849] Providers "feel intimidated by the inspectors" when they question the authenticity of their records, said Mbehero, and fear being seen as complicit in criminal activity.[850] Therefore, to avoid such questioning from healthcare inspectors, providers simply underreport their post-abortion care caseload.

The same holds true for accurate reporting of abortions. One nurse and post-abortion care trainer from Nairobi told the Center for Reproductive Rights of a recent training she conducted in Central Province for nurses providing post-abortion care and safe abortion services.[851] The nurse-trainer recounted,

> *When the District Health nurse saw these nurses' report they said they need to investigate because there were too many abortions. This was immediately after the IDP [persons internally displaced by the post-election violence] issue so a lot of women were seeking abortion because of rape. After that, they decided not to report the abortions they provide to the government.*[852]

She expressed frustration that "you can't get the true data on abortion because healthcare providers are writing reports to please government officials."[853]

A clinical officer at Kisumu East District Hospital also raised the issue of provider underreporting or inaccurate reporting of post-abortion care and abortion cases out of fear of prosecution. He cautioned, "Never record anything called abortion [including attempted abortion or post-abortion care]. If you put your signature there you are going down. The numbers at the hospital in the register are a public relations thing. They just make the figure up. They don't record."[854]

Providers in public healthcare facilities also choose not to record post-abortion care and abortion cases because, as documented in earlier sections, due to poor government oversight some are offering such services "privately" or "off the books,"[855] demanding bribes or greater fees for such services when women present late at night. Kagose of Suba District Hospital explained, "The figures they capture about abortions [post-abortion care] are not true figures. Some come at night and have to pay privately and are not recorded."[856] A clinical officer at Kisumu East District Hospital agreed that termination procedures went unrecorded at his hospital by those performing them for personal profit: "Abortion you can never record it because the whole money goes to your pocket. So if you put your signature and record . . . you'll be fired."[857]

Women, fearing the possible legal and social implications of being suspected of having terminated a pregnancy, also resist having their names recorded for having sought post-abortion care services.[858] As such, explained Kagose, "it's hard to register the people who come for PAC [post-abortion care]. People who are recorded are the ones who come for PAC for genuine miscarriage."[859]

The Division of Reproductive Health appears unaware of the magnitude of the documentation problem and its root causes. Although Dr. Kigen admitted that abortion statistics are poor and "the data is not good" because "abortions are done illegally," he believed that the "PAC [post-abortion care] data is fairly accurate."[860] When pressed, he acknowledged that "sometimes there is underreporting [of post-abortion care cases] because of the many tasks people have." However, he denied that providers underreport because they feel intimidated by healthcare inspection teams.[861] He explained that if the number of recorded post-abortion care cases is high, the Division responds with support: "we intervene—we work to train more people and improve family planning methods."[862]

Dr. Margaret Meme and Dr. Annie Gituto of the Division of Reproductive Health, in contrast, did express their concern about poor post-abortion care documentation, saying, "we get reports [of post-abortion care cases] but we still feel it's not everything that happens that we get."[863] However, they attributed this deficiency to the general weakness of the government's monitoring and evaluation (M&E) system: "It's a systemic problem—M&E and data collection is always weak."[864] When asked about provider intimidation as a potential cause of underreporting, Dr. Meme and Dr. Gituto replied that "PAC [post-abortion care] is not illegal so they should not be afraid [to report]. PAC is something that is sanctioned by the government . . . This is a government policy [that] we must save life. We always tell health workers they should record it. Our mandate is to save life, stop bleeding, and keep women healthy."[865] However, they acknowledged that if a health facility "gets worried about the documentation, the individual facility takes action" and underreports.[866]

Ultimately, whatever the cause, the lack of accurate documentation affects the ability of the Division of Reproductive Health to accurately assess and respond to post-abortion care and abortion service-provision needs. Dr. Kigen explained that the post-abortion care data "is for us for advocacy and to prioritize requests for more funding"[867]; however, Dr. Meme and Dr. Gituto acknowledged that "the data we get is not even sufficient for any action to be taken. We insist on them trying to make things better, but . . . "[868] This poor data collection presents a significant challenge to the Division in devising appropriate public health strategies to address the public health implications of unsafe abortion.

In addition, inadequate data collection prevents the Kenyan government from fulfilling its obligations regarding the right to health, as enshrined in the International Covenant on Economic, Social and Cultural Rights.[869] According to the Committee on Economic, Social and Cultural Rights, charged with issuing legally binding interpretations of the Covenant, a non-derogable, "core obligation" of a state party is "to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population."[870] This evidence should be collected in a manner that respects individuals' right to confidentiality. As the Committee clearly states, the "accessibility of information [concerning health issues] should not impair the right to have personal health data treated with confidentiality."[871] The lack of accurate epidemiological evidence concerning unsafe abortion and post-abortion care effectively prevents the Kenyan government from adopting a national public health strategy and plan of action that addresses the health concerns of the entire Kenyan population.

Structural Problems with Post-Abortion Family Planning Services

Interviews conducted with healthcare providers in the public health sector suggest that structural or design problems in the provision of family planning services impede effective family planning uptake for post-abortion care patients. Currently, family planning counseling and services in many public health facilities are located in a separate Maternal and Child Health or Family Planning (MCH/FP) clinic, distinct from the gynecology ward or outpatient location where post-abortion care patients are treated. Although referred by providers to the MCH/FP clinic for services, women must visit the clinic largely on their own initiative, after being discharged from the ward. According to providers interviewed for this report, this does not often occur.

A clinical officer at Kisumu East District Hospital explained that "family planning counseling after abortion depends on who sees you. Family planning is another section of the hospital. After I do [the procedure], they just go home. No family planning counseling."[872] The impact of this approach can be seen in the official statistics collected at Kisumu East District Hospital on post-abortion care: less than 33% of women who received post-abortion care services between January and June 2009 left with a family planning method.[873] In June 2009 alone, according to the register, not one of the 17 post-abortion care patients who were treated in the facility took up a family planning method upon discharge.[874]

Dr. Njoroge Waithaka, a gynecologist at KNH, has observed similar challenges due to the geographical separation of family planning services from the wards where post-abortion care patients receive treatment. He explained,

> *We try to do as much as we can in terms of family planning counseling. The way we are set up for now we don't have a nice counseling room for immediate post-abortal counseling. But we are in the process of putting in a counseling room where after MVA you can be counseled about contraception. [post-abortion care patients] are usually day care patients and you send them to the family planning clinic and they just go home [without going to the clinic for counseling].*[875]

According to Oguttu of KMET, an organization that trains private providers in post-abortion care, this problem is particularly prevalent in the public-sector: "In the private

sector, family planning uptake is higher than in the public [sector] because women are referred to another facility in the public-sector for family planning."[876] In smaller private-sector clinics, family planning services are provided in conjunction with post-abortion care and women are therefore more likely to leave the healthcare facility with a contraceptive method.

This design weakness in the provision of post-abortion care-family planning services in the public-sector is a missed opportunity; "studies in Latin America and Africa have shown that after having an abortion patients will accept contraception at high rates. Contraceptive counseling and provision at the time of treatment reduced unintended pregnancies and repeat abortions by 50% over one year in Zimbabwe, compared with post-abortion patients who did not receive such services."[877]

Recognizing the importance of family planning services in preventing unwanted pregnancies, the Division of Reproductive Health has made family planning a top priority. Dr. Kigen, head of the Division at the time of the interview, attributed the high rates of abortion and post-abortion care cases to "unmet family planning need. . . . Our priority is to ensure that family planning is available . . . contraceptive security, availability, and training of healthcare providers. That is our priority in the prevention of abortions."[878] However, Dr. Meme and Dr. Gituto of the Division acknowledged that "there is no system for follow up [with post-abortion care patients] in terms of [family planning] counseling. We insist on family planning but sometimes you find they don't come back even for family planning. They get lost along the way."[879]

Beyond the Impact on Women: Healthcare Providers and the Healthcare System

The Impact of Criminalization on Healthcare Providers

Healthcare providers who offer post-abortion care or abortion services are significantly affected by Kenya's restrictive abortion law in both their professional work and their personal lives. Providers and their families encounter police and community harassment, are forced to pay bribes to police, are criminally prosecuted, face employment discrimination due to the stigma surrounding abortion, and struggle with the internal personal and professional tension that the law creates, pitting their duty to save lives and promote health against their obligation to obey the law.

Provider–Patient Relationships Affected

Criminalization of abortion has a serious impact on healthcare providers' ability to abide by their professional responsibility and ethics when practicing medicine. The Medical Practitioners and Dentists Board's (Medical Board) Code of Professional Conduct and Discipline (Code of Conduct) refers to an explicit duty of doctors toward the sick: "A doctor must always bear in mind the obligation of preserving human life. A doctor owes to his patient complete loyalty and all the resources of his science."[880] The Code of Professional Conduct for Clinical Officers has a similar provision.[881] Providers can find themselves torn between their sworn duty to protect and promote their patient's health and the restrictive nature of Kenya's Penal Code, which limits the accessibility of a particular medical procedure and—exceptionally—infringes upon a provider's autonomy to decide what is best for the patient's health. No other medical procedure is treated in quite the same manner under Kenyan law; certainly, no other procedure is restricted by way of the Penal Code, with criminal penalties for the provider and the patient should the law be infringed upon.

As written in their Code of Conduct, medical practitioners are "strongly advised" to consult with two senior practitioners, obtain their consenting signatures, and perform the procedure in the hospital.[882] Dr. Boaz Nyunya, a professor of gynecology at Moi University, views the Medical Board's interpretation of the Penal Code provisions on abortion as "trying to make the doctors be the policemen. It is not to make the procedure safer but so that the procedure is done within the law."[883]

A provider, faced with a woman who requires a termination and aware that she will seek an unsafe abortion without his or her assistance, is left with a stark choice: risk criminal liability or knowingly allow the woman to risk her life and health. This places providers in a difficult position, leaving them to grapple with questions of morality and professional responsibility.[884]

The criminalization of abortion in Kenya also breeds distrust between healthcare providers and clients. Providers are uncertain whether the client seeking medical advice is a genuine client or someone seeking to portray them as offering illegal abortion services in order to extort money or have them arrested.

Providers interviewed for this report discussed how complicity between the media and the police in "exposing" abortion providers was a typical occurrence in the wake of the infamous 2004 *Republic v. Nyamu and Others* case, in which three healthcare providers were charged with the murder of several fetuses. [See Arrest and Prosecution: The Case of Dr. Nyamu and Nurses Kibathi and Mathai, p. 27].[885] Faith Mbehero of the National Nurses Association of Kenya said that "in 2005–2006 harassment of providers was very common. There were cases every other day."[886] A private nurse-midwife with her own clinic in Dandora, an informal settlement on the outskirts of Nairobi felt the same way:

> *At that time a lot of people came around trying to see who is trying to provide abortion—the government, the press. . . . They [would send in a woman pretending to seek an abortion and] want to find out if [providers offer abortion services], but aren't really seeking services. So you have to be very careful and take the total history and counsel and interview them and find out whether they know the law.*[887]

Mercy Mathai, a nurse charged in the Nyamu case, described the chilling effect that this technique has on providers:

> *You feel it's not comfortable. At times you talk to the client and they are seeking abortion services. When doing counseling you feel like the client is [actually] coming to investigate. We get these cases once in a while. City Council people are using a woman—she goes and then they record. [The woman] asks for services and she records providers. And then asks for bribes. Even if they take you to the cells, they will not take you to court. They put you in cells, threaten you and ask for money.*[888]

A Nairobi-based clinical officer told a similar story:

> *There was a time this was so common about one to two years ago. Used to witch hunt and send you a patient who was really pregnant and you talk and talk [about her situation and how she wants an abortion], and even sometimes they went with a small camera and the media was involved, and you agree on prices for the abortion and then the police would storm in. In most cases, the cases don't go to court. I have never heard of one taken to court. They ask for a bribe and then you are sent home.*[889]

This phenomenon creates a layer of suspicion between provider and client, doing little to foster a positive and trusting relationship between a genuine client in actual need of services and her provider. "A challenge for us is, is the client really seeking help or is she trying to see if you provide abortions," said the nurse-midwife working in Dandora.[890] She concluded, "You have to be strict about treating patients."[891] The challenges faced by providers who offer abortion or post-abortion care services are compounded by the fact that providers have limited avenues for redress for the harassment and bribery that they face.

On the other hand, women's distrust of providers leads them to seek unsafe, clandestine abortions rather than consult with a skilled medical practitioner and receive accurate medical advice and safe medical services. According to the nurse-midwife working in Dandora,

> *Clients are not seeking safe abortion because they are scared of the consequences. If things can change, the client and provider can be at ease. The clients don't trust*

us—they are worried that the provider is investigating them and the provider is trying to find out if they are laying a trap. Nobody is comfortable.[892]

A final layer of this relationship dynamic is the provider's relationship to the community. Research has revealed that a woman's community or family—more than anyone else—is generally responsible for reporting her and the provider to the police for suspected procurement of an illegal abortion. Tension with the community, often due to misinformation or a lack of understanding, can lead to problems for both women and their providers, and interfere with a provider's ability to operate his or her clinic effectively.

For example, the nurse-midwife working in Dandora was recently able to hire a doctor to work at her clinic, in addition to the existing nursing and clinical officer staff. However, she recounted that in early 2009, she

had a bit of a problem with the chief and police nearby. I think he [the chief] sent some spies to come and spy on what was going on and on the doctor. When he [the chief] came to the office—he said I understand that what you do with your staff is that you're procuring abortions and even if the baby was big you cut it into pieces and throw them away.[893]

The chief and police then asked her to dismiss the doctor. When she called the doctor to determine the source of these allegations, he said that a woman had come into the clinic whose fetus had died in her uterus when she was five months pregnant. The woman's husband saw the doctor removing the decomposing fetus and accused the doctor of carrying out an abortion. The story quickly spread throughout the community and culminated in the chief's ultimatum to the nurse-midwife: "if that is what he is doing there, get rid of him."[894] She and the doctor attempted to explain what had actually happened; however, the "community was excited and upset and they were coming to burn the clinic" and she had to let the doctor go.[895] "When they [the community] scream loud," she said, "they can spoil everything."[896]

A retired nurse with a private clinic in Mbita had a similar story of misunderstanding and tension between the community and healthcare providers. He recounted one of the challenges for healthcare providers in Mbita:

The chief of the area is not well informed and needs to be sensitized. Sometimes people gossip about someone who is terminating. If chiefs are not sensitized then they harass clients and healthcare providers. The chief enforces the law. . . . The community reports people who want to terminate to the chief and they harass the women and providers and force them into backstreet abortions. The chief refers cases to the police—this happens with abortion.[897]

The lack of awareness and education within a community about the nature and importance of the reproductive health services offered by a provider can lead to unjustified provider and client harassment by the community, resulting in clinic closings, an inability of clinics or trained providers to offer a full range of legitimate healthcare services, and women being forced to seek the unsafe and unskilled services of a backstreet practitioner.

Harassment and Bribes

Healthcare providers who offer post-abortion care or termination services often face stigma from fellow healthcare professionals or members of the public. Many are reluctant to speak out publicly on issues pertaining to abortion for fear of the controversy and backlash such efforts may produce. Dr. Ochiel, a gynecologist at the University of Nairobi, chose to initiate a public debate on unsafe abortion. In 2004, he went on national television to discuss abortion and what causes women to seek a termination. In the course of the interview he explained that he offered abortion services and why he does so; as he told the Center for Reproductive Rights: "My duty as a doctor is to help people, not to cause their death [by forcing them to resort to an unsafe abortion]."[898] Following the interview, Dr. Ochiel received death threats. His son and wife were harassed by their co-workers. For the sake of his family, Dr. Ochiel has since refrained from speaking publicly about the issue of abortion.[899] Following the death threats, Dr. Ochiel told his colleagues: ". . . that if I am killed, they should write, while notifying the registrar of deaths, that I died from unsafe abortion as the cause of death."[900]

In an effort to shut down clinics, some members of the public report to the Medical Board healthcare providers whom they suspect of providing abortions. These reports are often unsubstantiated or, at times, may originate from providers wishing to eliminate their competition for clients in the area.[901] The abortion law is also used as a ploy by families and partners seeking to settle personal vendettas and by police as a source of profit through extortion and bribery.

According to Dr. Julius Kyambi, chairman of the Medical Board, the Board has inspected and closed many clinics due to reports from members of the public and police of illegal abortions being performed there—in fact, "abortion is the commonest reason to close clinics," said Dr. Kyambi.[902] He explained that the Medical Board has not been able to get "people in the act, but when the public complains we look for another reason to close the clinic."[903] Dr. Daniel Yumbya, the Medical Board's chief executive officer, explained the process similarly: "[The police and members of the public] report that this is a clinic carrying out abortions, then we get other reasons for closing it."[904] The lack of rigorous standards of evidence for clinic closings means that members of the public can wield enormous power over the professional lives of healthcare providers, forcing them to be continually on guard against community interference even when providing legitimate health services.

Nowhere is this phenomenon more apparent than in the provision of government-sanctioned and-promoted post-abortion care services. Providers have been repeatedly deterred from offering post-abortion care services for fear of community and police harassment. The instruments and supplies for the provision of post-abortion care are often identical to those used in procuring abortions and, as a result, many providers have been accused of performing illegal abortions. Unwilling to face potential criminal charges for being complicit in providing illegal abortions simply because they were offering post-abortion care services to survivors of unsafe abortion, many providers choose not to offer post-abortion care at all.[905]

A clinical officer with a private clinic in the outskirts of Nairobi recounted his recent personal experience of dealing with the risk of post-abortion care provision:

> *Last year, around the beginning of June 2008, we had a problem. A girl came [to our clinic] who had been given pills somewhere. She bled and was brought by a friend. We had to do emergency PAC [post-abortion care]. When the patient's relatives came, it*

turned out the father was a policeman. They [the relatives/policeman] accused me of providing an abortion to the girl. Ten policemen came to my clinic. I had a card where I recorded everything—this was a genuine PAC case. So I had the card plus the patient testified. She said she had taken pills somewhere else to induce the abortion. They wanted to accuse me but the girl said it was her who took the pills elsewhere. This girl was brave—but sometimes they convince them [the girls] to blame the provider.[906]

This type of harassment deters the limited number of trained providers from offering much-needed post-abortion care services—and further discourages additional providers from being trained in post-abortion care provision.

Police Harassment

Many providers interviewed for this report recounted personal experiences with police harassment. Such harassment occurs primarily in private clinics or private hospitals and affects nurses, clinical officers, and doctors alike. Harassment may take the form of random police intrusions into health facilities or of targeted interventions resulting from community "tip-offs" or police initiatives—the latter often an effort to carry out personal retaliation or extort money from fearful healthcare providers.

For example, a nurse at a private hospital in Nairobi described an incident on June 17, 2009, in which police entered the hospital and began harassing the patients, questioning one about the nature of her medical care.[907] The patient explained, truthfully, that a fetal deformity required she obtain a legal termination; nonetheless, the police confronted the doctor on duty, demanded a bribe and left only after receiving some money. The nurse told of a similar incident in February 2009 in which the police walked directly into the gynecology wards but were unable to find any patients to interrogate. The "patients at the reception desk were furious," the nurse said.[908] Each incident involved a different set of police officers; according to the nurse, these incidents take place on a regular basis, every three to four months.[909]

A doctor employed in a private clinic in Kisumu recounted his own story of police harassment and arrest:

A lady disagreed with her husband and he kicked her in the abdomen. She came here when she was very sick. When she was fighting with her husband, the lady had said she was tired of him and wanted a termination. So when the lady came here for care after the fight, he suspected she was getting an abortion. The husband called the police. The police came to the clinic and asked for the doctor in charge. The police said they were arresting me and I asked: where is your warrant? They said they were arresting me because I was going to procure an abortion. I hadn't even seen the woman at all—I had been in the theatre when she came in. We went to the police station and I asked the OCPD [commanding officer] why I was being arrested. We had a meeting with the police chief and the woman and she said she had never seen me before or been treated by me. . . . I stayed in police custody for almost ten hours and they harassed me—they took my phone, made me take off my belt and shoes. There was nothing substantial about the charges so I was released. Usually you have to pay a bribe. There are a lot of guys who have been harassed and arrested. They wanted to try the woman and me but luckily the officer in charge was rational. People usually

> *aren't tried or charged—they are just arrested, pay a bribe and are released. They will arrest you and put your name in the press. So this deters providers from offering [post-abortion care]. If you want to provide a service and always have to be looking at your back to see if a policeman is around, it's a deterrent factor.*[910]

According to Dr. Joseph Karanja, a councilmember and former Chairman of the Kenya Obstetrical and Gynecological Society (KOGS), incidents of provider arrest, followed by a police demand for a bribe and then subsequent release after paying the asked-for sum, are becoming increasingly common.[911] Prosecution is rare and the entire incident of arrest is typically a police exercise in extorting a bribe from healthcare providers. This tactic has become particularly popular after the *Nyamu* case, perhaps because law enforcement feels that the chances of a successful prosecution are slim. Mathai, a nurse charged in the case, stated, "it's unlikely that it [a case like ours] would come up because they still feel they are going to lose. Nowadays they put the providers in the cells and after 3–4 days they release them."[912]

A clinical officer in Nairobi confirmed that such bribery incidents are not unique to doctors or gynecologists.[913] He told of a colleague who had experienced a similar situation:

> *[A girl's] parents and police accused the clinical officer of procuring an abortion. The clinical officer was put in a cell. The girl was not complaining [it was her relatives who involved the police]. They didn't take him to court, just asked for bribes of about 50–60,000 shillings. Then he was released and the whole thing stopped there.*[914]

Other Forms of Harassment

More recently, it appears that members of the public are using this scheme as an easy way to make money. Posing as policemen and journalists, these individuals storm a clinic with video cameras while the provider is in the midst of a procedure, and then demand money in exchange for not going public with the footage and arresting the provider. A Nairobi-based doctor was the victim of this scheme on November 2, 2009, when individuals claiming to be police officers from the Central Police Station and journalists from Kenya Television Network (KTN) barged into his clinic while he was performing a manual vacuum aspiration (MVA) procedure on a woman. He was forced to pay a 200,000-shilling ($2,632) bribe to these "policeman" and accompanying "journalists," whose credentials were vague. Similar incidents occurred on October 23, 2009, and October 8, 2009, in which each healthcare provider was required to pay 200,000 shillings in exchange for being left alone.[915] A meeting between Dr. John Nyamu, who sought to investigate the incident, and police officers from the Central Police Station revealed that these were "not genuine policeman" and that the Central Police Station was "not aware of any police operations in the CBD [Central Business District]."[916]

Dr. Karanja is certain that this is "extortion."[917] In discussing the November 2nd incident, he noted,

> *This is the second case in a month. [They are] becoming more frequent. . . . They pretend to be journalists. . . . They keep a watch and see when somebody who seems as if they're going for a procedure goes—they seem to time it. They came in in the middle of him doing an MVA. They [these incidents] have always happened sporadically but this year they seem to have become frequent.*[918]

Thus, the restrictive abortion law is often used as an easy method for extracting bribes or settling personal scores. Providers are extremely vulnerable to false accusations and inappropriate intrusions into their medical practice and the privacy of their doctor–patient relationships. Not surprisingly, these incidents have a chilling effect on the provision of post-abortion care and safe abortion services in Kenya.


Many women go to public hospitals only
when complications are severe and complex.

UNSAFE ABORTION'S COST TO KENYA'S HEALTHCARE SYSTEM

Unsafe abortion is a burden to the healthcare system. If you go to public-sector facilities, it is a major activity and constitutes a large percentage of resources—theater time, drugs, skill.[919]

—Dr. Ochiel, Gynecologist, former Chair of the Kenya Medical Association,

The cost of unsafe abortion to Kenya's healthcare system has yet to be comprehensively and systematically studied. Nonetheless, a 2004 study conducted by Ipas and the Ministry of Health provides some insight into the financial impact on the healthcare system, estimating that the total "annual direct cost for treating incomplete abortions presenting to public hospitals is approximately 18.4 million Kshs [$242,105]. About Ksh[s] 11.5 million [$151,316] (62% of the total) are spent on treating unsafely induced abortions."[920] Significantly, "[t]he study population was restricted to complications stemming from abortions performed before 22-weeks gestation and, therefore, did not include late-term abortions, which are riskier procedures that could be expected to result in a higher rate of complications and mortality"[921] and, presumably, higher direct treatment costs.

Further, direct cost is defined by the study to include up-front costs associated with personnel and medical supplies[922] and does not include additional costs such as overnight stays for those with serious complications or indirect costs such as the medical costs of treating long-term health effects.[923] Thus, the study's estimates are likely substantial underestimates. Kenyan gynecologist J.K.G. Mati has suggested instead that "a very conservative estimate of the annual cost to Kenya [of the management of botched abortion] is of the order of 250–300 million [Kenyan] shillings [$3.3–4 million approximately]."[924]

The cost of treating incomplete abortions necessarily varies by the severity of the complications and the level of facility. According to the study, the average cost per patient is 2,125.35 shillings ($28) for tertiary hospitals; 1518.46 shillings ($20) for provincial hospitals; and 673.88 shillings ($8.90) for district hospitals.[925] To place these numbers in context, the government per capita expenditure on health in Kenya at the time of the study was approximately 500 shillings ($6.20).[926]

Dr. Karanja told the Center for Reproductive Rights of one woman who came in for post-abortion care in August 2008:

> *She had major abdominal surgery, spent time in the ICU [intensive-care unit], had a second operation and then after [the second operation spent] 8 months in the ward. Eventually she was OK and she had accumulated a bill of a quarter of a million shillings and couldn't pay. She came from Kawangware slums, was 20 years old, . . . and had a hysterectomy. . . . She ended up not paying hardly anything because she couldn't afford it. So when you have several of those over the year it's quite a drain on the hospital budget.*[927]

Although the actual direct cost of unsafe abortion is difficult to assess in a restrictive legal environment, the findings by the Ipas/Ministry of Health study that 20,893 women with incomplete abortions,[928] at least half of which are likely induced abortions, are treated per year in public hospitals alone demonstrates that the impact on Kenya's healthcare system is undeniably substantial. (This figure does not include private facilities and lower-tiered facilities such as health centers and maternities.)

Treating complications from unsafe abortion significantly strains the already limited funds, staff, and medical supplies available to Kenya's public health system, diverting scarce resources to an easily preventable public health problem. Gynecology wards and maternal health-related services experience this financial impact most acutely. A report by the International Planned Parenthood Federation, for example, concluded that "[t]he impact [of unsafe abortion] on the resources of Kenya's healthcare system is enormous, with as much as 60 per cent of the resources of Kenyatta National Hospital's maternity ward taken up by victims of unsafe abortions."[929] A study carried out at Kenya's Kakamega Provincial General Hospital found that "abortion was the most common acute gynecological ailment with its complications accounting for the longest hospital stay in comparison with other acute gynecological conditions."[930]

The health-related costs of unsafe abortion are exacerbated by the fact that many women in Kenya appear to wait until their second trimester to procure an abortion and that most healthcare providers are not trained to deal with second-trimester abortion or post-abortion care cases. One study on abortion complications in Kenya, which surveyed 809 patients with abortion complications in 54 district hospitals nationwide, found that "over a third of the women admitted with abortion complications were in the second trimester of pregnancy."[931] Abortions procured in later trimesters are associated with increased health risks and greater complications,[932] and thus a greater diversion of

healthcare system resources. The study further found that "second trimester abortion cases had higher odds of being in the moderate or high [severity] category than first trimester abortion cases"[933] and six of the seven deaths from abortion complications in the study sample were the result of second-trimester complications.[934] Kenya has a relatively high case-fatality rate from abortion complications when compared to regional and global statistics on abortion-related mortality.[935]

The considerable burden of unsafe abortion on the healthcare system is largely a function of Kenya's restrictive abortion law. In addition to forcing women to resort to unsafe abortions—and thereby creating the high demand for post-abortion care—criminalizing abortion also drives up the cost of abortion services and can cause women to wait until their second trimester, when they have saved up enough money, to seek termination services. This practice, as mentioned above, results in greater complications, longer hospital stays, and, inevitably, greater use of the health system's resources. Criminalization also prevents women from seeking timely post-abortion care due to fear, a lack of knowledge about services, stigma, and the often-prohibitive cost of post-abortion care. Thus, many women go to public hospitals only when complications are severe and complex, requiring more resources and extended hospital stays. This is evidenced by the aforementioned study's finding that 27.9% of women presenting at hospitals in Kenya had complications of high severity.[936]

In addition, criminalization of abortion in Kenya has created an environment in which unsafe abortion has become a public-health crisis that most healthcare administrators and policymakers are content—and permitted—to ignore. This strategy is not optimal, particularly from a public health, cost-benefit perspective. As Dr. Joachim Osur, a Kenya reproductive health specialist, described the current Kenyan context, "it's like waiting for people to get measles and then treating them for measles."[937] Said Dr. Osur, "what we are doing now is not making sense in the public health arena."[938]

Ultimately, reducing the cost burden of unsafe abortion is simply a matter of providing safe, accessible abortion services to women. This point is best illustrated in a 2006 *Lancet* article on unsafe abortion, which reported that "[e]stimates from Uganda comparing costs of treatment of abortion complications with costs of providing safe, elective abortion show the potential resource-savings to health systems. Post-abortion care offered in tertiary hospitals by physician providers was estimated to cost health systems ten times more than elective abortion services offered by mid-level practitioners in primary care."[939] Further, as the *Lancet* article pointed out, "making abortion legal, safe, and accessible does not appreciably increase demand . . . [h]ence, governments need not worry that the costs of making abortion safe will overburden the healthcare infrastructure."[940]

Human Rights Violations in the Context of Abortion and Post-Abortion Care

The findings of this report have more than just public health implications. They also reveal serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the right to life; the right to health; the right to liberty and security of person; the right to be free from torture and cruel, inhuman, or degrading treatment; the rights to equality and non-discrimination; the right to dignity; the right to information; the right to privacy and family; and the right to redress and legal assistance. The violations described in this report demonstrate that Kenya is not honoring its domestic and global commitments to respect, protect, and fulfill these rights.

Kenya Has Committed Itself to International and Regional Standards which Affirm Women's Human Rights

Several regional treaties—the African Charter on Human and Peoples' Rights (African Charter),[941] the African Charter on the Rights and Welfare of the Child (African Charter on Children),[942] and the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol)[943]—provide important protections for the rights of women and girls in Kenya. The Kenyan government has ratified the African Charter and the African Charter on Children, and has signed but not yet ratified the Maputo Protocol.[944] However, even by signing the Maputo Protocol, which offers the most explicit recognition and protection of reproductive rights in the African regional system, Kenya is obligated to refrain from acting in a way that "would defeat the object and purpose of [the] treaty,"[945] which includes "the full realisation of the rights" recognized in the treaty.[946] Although Kenya is not legally bound by the protocol itself, it should not act in any manner that would contravene the protocol's intent and render performance of the protocol's obligations impossible or more difficult.

Kenya has also confirmed its commitment to upholding international human rights standards by ratifying several major global treaties, including the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant),[947] the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant),[948] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[949] the Convention on the Rights of the Child (Children's Rights Convention),[950] and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture).[951] A state that ratifies or accedes to an international convention "establishes on the international plane its consent to be bound by a treaty."[952] The government of Kenya is therefore obligated under international law to protect the rights guaranteed by these instruments. However, with the exception of the Children's Rights Convention, Kenya has failed to domesticate the provisions of these treaties through national-level laws. Furthermore, Kenya has not yet ratified the optional protocols to the Civil and Political Rights Covenant, CEDAW, or the Convention against Torture—all of which would permit individuals to submit rights-violation claims directly to the relevant monitoring body, as established by each treaty, after exhausting domestic remedies.

The legally binding provisions of the major human rights conventions are complemented by politically binding international consensus documents that support a globally recognized reproductive rights framework. These include the outcome documents of international conferences such as the United Nations International Conference on Population and Development, the Fifth African Regional Conference on Women, and the United Nations Fourth World Conference on Women—all of which Kenya participated in.[953] Moreover, Kenya has committed itself to attaining the United Nations Millennium Development Goals, which prioritize promoting gender equality, reducing maternal mortality, and ensuring universal access to education as key development issues for the new millennium.[954]

Key Human Rights Treaties Affirm Women's Reproductive Rights, including the Right to Safe and Legal Abortion Services and Quality Post-Abortion Care

The government of Kenya is legally bound to respect, protect, and fulfil the following rights pursuant to the international and regional conventions that it has signed or ratified.

Right to Life

The Civil and Political Rights Covenant, the Children's Rights Convention, the African Charter, and the Maputo Protocol, along with other international treaties, all protect the fundamental right to life.[955]

The Human Rights Committee has made clear that the right to life in the Civil and Political Rights Covenant should not be narrowly interpreted and requires that states adopt positive measures, including taking "all possible measures" to increase life expectancy.[956] The Committee has stated that such measures include those "taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions."[957] The Committee recognizes that illegal and unsafe abortion violates a woman's right to life,[958] and has linked illegal and unsafe abortions to high rates of maternal mortality.[959] In its concluding observations for Kenya, pertaining to the right to life, the Human Rights Committee has "expresse[d] concern about the high maternal mortality rate prevalent in the country, caused, inter alia, by a high number of unsafe or illegal abortions."[960]

The Committee on the Rights of the Child (Children's Rights Committee), which monitors compliance with the Children's Rights Convention, has also repeatedly linked maternal mortality to high rates of illegal,[961] clandestine,[962] and unsafe abortions[963] among adolescents. In concluding observations for Kenya, the Children's Rights Committee has expressed concern about "the criminalization of the termination of pregnancies in cases of rape and incest . . . [and its contribution] to the elevated incidence of maternal mortality among adolescent girls."[964] On several occasions, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) has explicitly recognized that maternal mortality due to unsafe abortion is a violation of a woman's right to life;[965] the CEDAW Committee has also made the link between barriers to accessing post-abortion care and high rates of maternal mortality.[966] In its concluding observations for Kenya, the CEDAW Committee has "expresse[d] its concern that the maternal mortality rate, including deaths resulting from unsafe abortions . . . remain[s] high"[967] and recommended that Kenya increase "access to safe abortion" in order to "step up its efforts to reduce the incidence of maternal . . . mortality."[968]

In addition, "treaty-monitoring bodies," or committees—including the Human Rights Committee and the CEDAW Committee—have consistently criticized restrictive abortion laws, often framing such laws as violations of the right to life.[969] These committees have called upon states parties on multiple occasions to legalize and decriminalize abortion, particularly when a pregnancy is life threatening.[970] The Human Rights Committee, for example, has expressed concern to one state party over a measure—similar to the Medical Practitioners and Dentists Board's provision on abortion in Kenya—that requires a woman to obtain the consent of three physicians before she can undergo an abortion, stating that it "may constitute a significant obstacle for women wishing to undergo legal and therefore safe abortion" and urged the state party to amend its laws to prevent women from putting their lives at risk by resorting to unsafe abortion.[971] The Human Rights Committee has noted that restrictive abortion laws and unsafe abortion fuel maternal mortality in Kenya and recommended, in concluding observations for Kenya pertaining to the right to life, that the government "review its abortion laws, with a view to bringing them into conformity with the Covenant."[972]

International and African Human Rights Treaties Have Not Recognized a Fetal Right to Life

"Fetal rights," equivalent to the rights of the pregnant woman, are not recognized in international human rights law or in African regional human rights treaties. This is evident in the committees' concluding observations and general recommendations detailed above, and throughout this section, that criticize restrictive abortion laws and express concern about their impact on women's rights to life and health, call for increased access to safe abortion services, and recommend decriminalization of abortion—behavior inconsistent with the recognition of a fetal right to life. It is also clear in the refusal by the drafters of human rights treaties to provide comprehensive legal protections before birth. For example, every international and African human rights instrument that Kenya has signed or ratified rejects the proposition that life begins prior to birth.

Article 1 of the Universal Declaration of Human Rights (Universal Declaration) opens with the fundamental statement of inalienability: "All human beings are born free and equal in dignity and rights."[973] Significantly, the history of the negotiations (*travaux préparatoires*) indicates that the word "born" was used intentionally to exclude the fetus or any antenatal application of human rights. The Civil and Political Rights Covenant likewise rejects the proposition that the right to life, protected in article 6(1), applies before birth. The drafters specifically rejected a proposed amendment that stated, "the right to life is inherent in the human person from the moment of conception, this right shall be protected by law."[974] Similarly, the drafting history of the African Charter makes clear that the Charter does not recognize the right to life prior to birth.[975]

Although the text of CEDAW does not explicitly protect the right to life, its preamble reaffirms the Universal Declaration's recognition that "all human beings are born free and equal in dignity and rights."[976] The Maputo Protocol, intended to supplement and elaborate upon the women's rights provisions in the African Charter, also does not address when life begins. Rather, it emphasizes women's right to life and offers groundbreaking protections for women's health. Article 14 explicitly outlines a woman's right to abortion in a range of circumstances: "States Parties shall take all appropriate measures to . . . protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus . . ."[977] This language implicitly affirms that the right to life does not begin until birth and cannot be read consistently with any other interpretation of the right to life.

The Right to the Highest Attainable Standard of Health

International and regional treaties and covenants repeatedly recognize the fundamental right to the highest attainable standard of physical and mental health, and impose an obligation on states to enforce this right.[978] The right to health is not confined to the right to health care, but includes freedom from interference with one's health, the right to control one's health and body, and the right to access essential health information.[979] [See Right to Information, p. 139]. A state's principle obligation with respect to the right to health under the Economic, Social and Cultural Rights Covenant is to take steps "with a view to achieving progressively the full realization of the rights recognized" in the covenant.[980]

The concept of progressive realization constitutes recognition of the fact that while full realization of all economic, social, and cultural rights may not be feasible in a short period of time, each state nonetheless has an obligation to move as expeditiously and effectively as possible towards the realization of these rights, "to the maximum of its available resources."[981] Notably, the Committee on Economic, Social and Cultural Rights (ESCR Committee) has said that a "violation of the obligation to fulfill" regarding the right to health can occur when there is "insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized."[982] The Kenyan government's failure to allocate the required resources to adequately train providers on safe abortion and post-abortion care services, and to procure the necessary equipment and supplies to provide such services, demonstrates a severe neglect of health services that only women need. These shortcomings discriminate against women and violate Kenya's obligation to fulfill the right to health.

Restrictive Abortion Laws and Lack of Access to Quality Post-Abortion Care Violate Women's Right to Health

International treaties and committees have explicitly addressed the impact of restrictive abortion laws on women's health and affirmed the right to access to emergency care, such as post-abortion care. Recognizing the importance of access to safe and legal abortion, the Maputo Protocol, under the right to health, calls upon states to "provide adequate, affordable and accessible health services" to women and to establish and to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."[983] In addition, committees have recognized that restrictive abortion laws are an important cause of unsafe abortion and high rates of maternal mortality.[984] For example, in 2009, the ESCR Committee urged a State party to comply with its obligations under the right to health by undertaking "legislative and other measures, including a review of its present legislation, to protect women from the effects of clandestine and unsafe abortions and to ensure that women do not resort to such harmful procedures."[985] The ESCR Committee and the Children's Rights Committee have both expressed concern over Kenya's restrictive abortion laws, particularly the criminalization of abortion in the context of rape and incest, when discussing the right to health and adolescent health in Kenya.[986]

Regarding post-abortion care, the Committee against Torture has emphasized that states must ensure "immediate and unconditional treatment of persons seeking emergency medical care [as a result of illegal abortion]."[987] Further, the CEDAW Committee has interpreted fulfillment of the right to health to entail providing "access to quality services for the management of complications arising from unsafe abortion."[988] More generally, the Children's Rights Convention and the African Charter on Children

affirm the right to "necessary medical assistance and health care,"[989] and the African Charter obligates states to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[990]

As this report has documented, Kenya's restrictive abortion law leads women with unwanted pregnancies to seek unsafe abortions, which can result in serious illness, life-long disability, or death. [See The Toll of Unsafe Abortion, p. 22]. Other women, who are forced to carry an unwanted pregnancy to term, may also experience mental and physical health consequences. [See Rights Implications of Being Forced to Carry a Pregnancy to Term, p. 72]. For these reasons, the ESCR Committee, the Human Rights Committee, and the Committee on the Rights of the Child have all expressed concern about the criminalization of abortion in Kenya; and the ESCR Committee has explicitly recommended that Kenya decriminalize abortion in certain situations.[991]

The health and lives of Kenyan women are threatened by the inadequate provision of medical services, specifically the lack of appropriately trained providers who can offer safe abortion and post-abortion care services, particularly in the second trimester; the lack of basic supplies, such as MVA equipment; and service provision in unhygienic conditions due to limited supplies of MVA kits and sterilization equipment. In addition, the widespread delays and neglect in providing post-abortion care and abortion services, degrading treatment and verbal abuse that women face when seeking and obtaining post-abortion care in Kenyan health facilities, and failure to provide appropriate pain medication during abortion or post-abortion care procedures constitute egregious violations of the right health. The trauma of these negative experiences can discourage women from seeking reproductive healthcare services in the future, which has an ongoing, adverse long-term impact on their health and lives.

Availability, Accessibility, Acceptability, and Quality

The ESCR Committee, in its General Comment on the right to the highest attainable standard of health, maintains that the essential components of the right to health are "availability, accessibility, acceptability and quality of health facilities, goods and services."[992]

The principle of availability requires that states have "functioning public health and healthcare facilities, goods and services" and that they are "available in sufficient quantity."[993] In this regard, the ESCR Committee has stated that states parties have a core, non-derogable obligation "[t]o provide certain essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs."[994] According to the World Health Organization's 2009 Model List of Essential Medicines, oral hormonal contraceptives which includes emergency contraception, injectable hormonal and implantable contraceptives, intrauterine devices, and barriers methods such as condoms,[995] as well as misoprostol,[996] are all part of the core list "of minimum medicine needs for a basic health care system."[997] The limited and inconsistent availability of contraceptives in Kenyan health care-facilities is a violation of Kenya's obligation to provide essential drugs. The other barriers that women encounter when trying to access contraception also violate their right to health. [See Lack of Access to Contraceptives, p. 44]. Delays and financial obstacles, misinformation about family planning, stockouts of preferred methods, and inability to access emergency contraception at many facilities lead to unwanted pregnancies, which can have negative and far-reaching consequences on women's health and well-being.

In addition, the World Health Organization has recently released an Interagency List of Essential Medical Devices for Reproductive Health; included on the list of devices is a "Manual Vacuum Aspiration instrument," which should be available at the first level of maternal care and at the referral level."[998] The fact that only 16% of Kenyan healthcare facilities have MVA equipment[999] is arguably both a violation of the right to essential healthcare goods and a violation of Kenya's obligation to ensure the availability of services, which include post-abortion and termination services.

The principle of accessibility requires that states ensure that medical services are "accessible to everyone without discrimination."[1000] Ensuring "the right of access to health facilities, goods and services on a non-discriminatory basis" is part of states parties' core, non-derogable obligation under article 12 of the Economic, Social and Cultural Rights Covenant.[1001] Health facilities, goods, and services must be both physically and financially accessible.[1002] A woman's right to health is violated when health services are not "within safe physical reach."[1003] Women, particularly poor women, who face security concerns when attempting to access emergency post-abortion care services at a healthcare facility might experience a violation of their right to health.

A woman's right to health is also violated when she cannot access healthcare services because of her financial status. The ESCR Committee has elaborated that "[e]quity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."[1004] Healthcare "goods and services must be affordable for all . . . whether privately or publicly provided."[1005] The refusal to treat women or provide them with access to safe abortion or post-abortion care because they cannot afford fees associated with this treatment regime, and the limited availability of appropriate post-abortion care and abortion services in rural areas that requires rural women to pay additional and prohibitive transportation costs to access services, violates poor and rural women's right to health.

The principle of acceptability mandates that all health facilities and services "be respectful of medical ethics" and "designed to respect confidentiality and improve the health status of those concerned."[1006] Providers who deny or delay abortion-related treatment based on religious or moral beliefs and fail to refer the woman to a willing provider are in breach of the ethical duty to refer; this practice violates a woman's right to health. [See International Medical Standards on Provider Refusals to Offer Services on Religious or Moral Grounds, p. 66].

Finally, healthcare services and goods "must also be scientifically and medically appropriate and of good quality."[1007] This requires the presence of "skilled medical personnel."[1008] The ESCR Committee has explained that, under the Economic, Social and Cultural Rights Covenant, "States have to ensure the appropriate training of doctors and other medical personnel . . ."[1009] The former Special Rapporteur on the Right to Health has addressed this obligation, stating that "[w]here abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible."[1010]

The Kenyan government's repeated failure to procure quality and medically appropriate MVA kits to use in post-abortion and abortion care; ensure the availability of misoprostol—a newer, safer, less invasive and more medically appropriate method for both abortion and post-abortion care; and train healthcare providers in the respectful and skilful provision of post-abortion and abortion care—particularly second-trimester abortions—violates women's right to quality health care. With regard to the issue of the

respectful provision of care, the CEDAW Committee has explicitly urged Kenya, when discussing issues of maternal health and mortality and barriers to women's access to healthcare services, "to ensure that health workers adopt a client-friendly attitude that will lead to improved access to quality health care."[1011] Subjecting women who require post-abortion care to verbal abuse and denying them access to pain medication is clearly a violation of the right to quality health care.

Misoprostol: An Important Tool in Fulfilling Women's Right to Health

Misoprostol is an important, and—in Kenya—underutilized, tool in the provision of safe abortion and post-abortion care services.

Misoprostol: "A medication that causes the cervix to soften and the uterus to contract. Can be used to prevent and treat postpartum hemorrhage, treat incomplete abortion and miscarriage, induce abortion (by itself or with mifepristone), and induce labor."[1012]

Benefits: Misoprostol is a form of "[m]edical abortion [that] can be used without significant facility space, medical equipment or highly trained providers, which makes it suitable for even the lowest resource settings and the most local levels of care."[1013] In addition, misoprostol is inexpensive, easy to store, eliminates the need to wait for equipment to be sterilized before administration, and circumvents the risks of surgical injury and related infection that comes from surgical evacuation.[1014] In some countries, the availability of misoprostol has been linked to lower rates of abortion complications and maternal morbidity,[1015] and to the use of safer abortion methods.[1016]

The Right to Liberty and Security of Person

The Civil and Political Rights Covenant and the African Charter both guarantee the right to liberty and security of person. Under both treaties, the right to liberty protects against arbitrary arrest and detention. Similar to language in the African Charter, the Civil and Political Rights Covenant further states, "No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law."[1017] The arrest and imprisonment of women in Kenya for procuring illegal abortions and the threat of arrest for women who seek post-abortion care violate a woman's right to liberty and security.

The right to security of person encompasses a notion of physical integrity which is violated by the denial of access to safe abortion services and post-abortion care. The former Special Rapporteur on Violence against Women has noted that laws and policies restricting access to safe abortion "can lead to devastating health consequences—in many cases, compromising a woman's right to life and security of person."[1018]

Finally, the practice of detaining patients who are unable to pay their medical bills violates the right to liberty, along with a number of related human rights affected by the deprivation of liberty, including the right to work, the right to freely participate in the cultural life of the community, and the right to move freely within state borders.[1019]

The Right to Freedom from Torture and Cruel, Inhuman, or Degrading Treatment

International human rights bodies have recognized that the denial of access to safe and legal abortion may violate the right to be free from torture and cruel, inhuman, or degrading treatment. In addition, the denial of access to post-abortion care, verbal abuse around the provision of abortion and post-abortion care, denial of appropriate pain management and medication, and the detention in health facilities documented in this report all constitute serious violations of the right to be free from torture and cruel, inhuman, or degrading treatment.

The right to be free from torture and cruel, inhuman, or degrading treatment is both a facet of customary international law[1020] and specifically protected by several international and regional conventions that Kenya has ratified, such as the Civil and Political Rights Covenant, the African Charter and the Convention against Torture.[1021] According to the African Charter, "All forms of exploitation and degradation . . . particularly . . . torture, cruel, inhuman or degrading punishment and treatment shall be prohibited."[1022] Cruel, inhuman, or degrading treatment is not restricted to acts that cause physical pain; it also encompasses actions that result in mental suffering.[1023] The Human Rights Committee has clearly stated that the protection against cruel, inhuman, or degrading treatment applies to medical institutions.[1024] The Committee also specifies that public authorities have a duty to protect a country's citizens from inhuman or degrading treatment, even when persons acting without official authority commit these acts.[1025]

Committees that monitor compliance with key human rights treaties have recognized that restrictive abortion laws and denials of access to safe abortion constitute violations of the right to be free from cruel, inhuman, or degrading treatment. The Human Rights Committee has made clear that compliance with this right under the Civil and Political Rights Covenant requires "access to safe abortion to women who have become pregnant as a result of rape."[1026] In addition, the Human Rights

Committee has "note[d] with concern" the case of Morocco, where—similar to Kenya—abortion is criminalized except to save the pregnant woman's life, and stated that, "The State party should ensure that women are not forced to carry a pregnancy to full term where that would be incompatible with its obligations under the Covenant [the right to life and the right to be free from torture and cruel, inhuman and degrading treatment] and should relax the legislation relating to abortion."[1027] Kenya's failure to include an explicit exception to its abortion law beyond a life exception, particularly for women who become pregnant due to rape, constitutes a violation of these women's right to be free from torture and cruel, inhuman, or degrading treatment.

Further, in *K.L. v. Peru*, the Human Rights Committee found that compelling a woman to continue a pregnancy that posed risks to her health and life was a violation of the right to be free from cruel, inhuman, or degrading treatment or punishment. Viewing the psychological harm arising from the continued pregnancy as foreseeable, the Human Rights Committee found that the mental suffering caused by the petitioner's forced pregnancy was a violation of article 7, the right to be free from torture and cruel, inhuman or degrading treatment, which "relates not only to physical pain but also to mental suffering."[1028]

As demonstrated in *K.L. v. Peru*, the Human Rights Committee has recognized that the goal of article 7 is "to protect both the dignity and the physical and mental integrity of the individual."[1029] Denying women access to post-abortion care, or conditioning care on a "confession" of procuring an illegal abortion, and thereby forcing them to endure both physical pain and mental suffering, is also a violation of the right to be free from torture and cruel, inhuman, or degrading treatment.

The Committee against Torture has addressed the relationship between criminalizing abortion and cruel, inhuman, and degrading treatment as well. The Committee has expressed concern regarding legislation that severely restricts access to voluntary abortion, particularly in cases of rape, and has urged such countries to consider creating exceptions to the criminalization of abortion.[1030] In particular, the Committee has recognized that "prohibitions of abortion . . . even in cases of rape [and] incest" cause mental suffering, noting that "[f]or the woman in question, this situation entails constant exposure to the violation committed against her and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression."[1031] Further, in the context of post-abortion care, the Committee against Torture has stated in concluding observations that "[in accordance with World Health Organization guidelines, the State party should ensure immediate and unconditional treatment of persons seeking emergency medical care."[1032] The extended delays experienced by women seeking post-abortion care in healthcare facilities in Kenya are a violation of the right to be free from torture and cruel, inhuman, or degrading treatment.

In addition to the denial of or delay in access to critical, life-saving services such as abortion and post-abortion care, the treatment that women receive when obtaining such services may constitute a violation of the right to be free from torture and cruel, inhuman, or degrading treatment. The verbal abuse experienced by women seeking post-abortion care in healthcare facilities in Kenya infringes upon women's psychological integrity, and treatment without anaesthesia or any form of pain management, despite its availability, causes women physical and emotional suffering [see Inadequate Pain Management, p. 93].[1033] Finally, the practice of detaining women in medical facilities because they cannot pay their medical bills, which may result in both mental and physical suffering, is also a violation of the right to be free from torture and cruel, inhuman, or degrading treatment. [See Fee Waivers and Detention of Patients in Healthcare Facilities, p. 83].

Right to Equality and Non-Discrimination

The denial of access to safe abortion and post-abortion care services, and the abuses that women encounter in health facilities due to Kenya's restrictive abortion laws, discriminate against women because they relate to healthcare services that only women need. Differences in healthcare services that women receive based on their ability to pay also violate the rights to equality and non-discrimination, as does disparately harsh treatment of younger women.

The rights to equality and non-discrimination—regardless of gender, age, or financial resources—are bedrocks of human rights doctrine and fundamental principles of international and regional law.[1034] Every human right discussed in this section must be exercised without discrimination.[1035] The African Charter not only declares that all individuals are "equal before the law," but also specifically requires states to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[1036] Similarly, the Maputo Protocol calls upon states to reform laws and practices that discriminate against women.[1037]

Restrictive abortion laws, by their nature, discriminate against women. The Human Rights Committee has noted the importance of access to safe abortion services, particularly in cases of rape, in ensuring women's equality.[1038] The CEDAW Committee has explained that discriminatory "barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo these procedures."[1039] The Committee recommends that "[w]hen possible, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion."[1040]

Kenya's restrictive abortion law discriminates against women, as does the government's failure to prevent and treat unsafe abortion by providing meaningful access to contraceptives and offering appropriate and accessible post-abortion care treatment. In addition, Kenya's failure to enact laws or policies that require providers who object to providing abortion services to refer women to providers who will offer such services violates women's right to equality and non-discrimination. Finally, from the limited data available, and as discussed in this report [see Arrest and Prosecution, p. 68], criminal sanctions relating to abortion appear to be imposed almost exclusively on women in Kenya. The uneven enforcement of Kenya's abortion law, resulting in the disproportionate arrest and prosecution of women, as compared to unqualified or untrained abortion providers or men who are complicit in procuring abortions, is discriminatory against women.

Women also experience discrimination when they are denied access to safe abortion services and forced to carry an unwanted pregnancy to term. The responsibility of bearing and raising a child falls disproportionately on women and these women may consequently be unable to exercise other rights guaranteed to them under international law, such as the right to education, on an equal basis with men [see Rights Implications of Being Forced to Carry a Pregnancy to Term, p. 72].

Any differences in healthcare services that women receive based on their ability to pay also violate the rights to equality and non-discrimination [see The Prohibitive Cost of Safe Abortion, p. 59; Costs Associated with Post-Abortion Care Prevent Access to Services, p. 80]. Recognizing this, the Human Rights Committee has expressed concern to one state party "over discriminatory aspects of the laws

and policies in force, which result in disproportionate resort to illegal, unsafe abortions by poor and rural women."[1041]

In Kenya, poor and rural women, who typically do not have meaningful access to private-sector health care, have much more limited access to safe abortion services than those who can afford services in the private sector. In addition, poorer women are forced to resort to public health facilities for post-abortion care, where they are often subject to verbal abuse and poor treatment—such behavior is less common in the private sector. Further, high costs impede women's ability to obtain post-abortion care services, resulting in women being turned away from hospitals while suffering post-abortion complications or being detained after receiving care. The inconsistent and ineffective implementation of fee exemptions and the degrading and lengthy fee-waiver process have done little to remedy this inequality.

Finally, discrimination against those who seek contraceptives in the public sector is also pervasive—many of the girls and women interviewed said that they would rather seek family planning services in the private sector if they could afford to do so. Concerned about these inequalities in access to healthcare services and their impact on the "high number of unsafe clandestine abortions" in Kenya, the ESCR Committee has recommended that Kenya

> *ensure affordable access for everyone, including adolescents, to comprehensive family planning services, contraceptives and safe abortion services, especially in rural and deprived urban areas, by eliminating formal and informal user fees for public and private family planning services, adequately funding the free distribution of contraceptives . . . and decriminalizing abortion in certain situations, including rape and incest.*[1042]

Abuses of women seeking abortion and post-abortion care services in Kenyan health facilities also violate the equal rights of women to health by preventing women "from accessing and benefiting from health care on a basis of equality."[1043] Abuse motivated by or related to one's gender violates the rights to equality and non-discrimination—verbal abuse relating to women's sexuality by healthcare providers, targeted towards women seeking abortion related services is an example of this type of gender discrimination. The CEDAW Committee has noted this in its most recent concluding observations for Kenya, voicing concern "that negative attitudes of health workers may be an impediment to women's access to health care services."[1044]

The verbal abuse and denial of services encountered by young women who seek contraceptives in health facilities constitutes added discrimination on the basis of age. The government is required to remedy any such discrimination in both the public and the private sectors.[1045]

Right to Dignity

Restrictive abortion laws that force women to resort to unsafe abortion, abusive treatment towards women seeking post-abortion care in healthcare facilities, detention in health facilities, and difficulties seeking redress for rights violations all infringe upon the right to dignity.

Human dignity is a foundation of human rights.[1046] The right to dignity is recognized and protected by various international and regional instruments, including the Civil and Political Rights Covenant, which

states that "the inherent dignity" of the human person is at the source of all other human rights.[1047] CEDAW recognizes "that discrimination against women violates the principles of equality of rights and respect for human dignity."[1048] The African Charter echoes this concept: "Every individual shall have the right to the respect of the dignity inherent in a human being."[1049] Furthermore, the Maputo Protocol requires states to "adopt and implement appropriate measures to ensure the protection of every woman's right to respect for her dignity."[1050] The African Charter on Children makes several references to the governmental obligation to protect dignity.[1051]

Criminalizing a safe medical procedure and forcing women to resort to crude methods of unsafe abortion—either self-induced or performed by unqualified individuals—violates their right to dignity. The verbal abuse and denial of pain management that women face while obtaining post-abortion care in Kenyan health facilities and the practice of indefinitely detaining patients who are unable to pay their medical bills also violate the right to dignity.

Right to Information

> *Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling.*[1052]
> ***— Beijing Platform for Action***

The failure to provide women with information about their right to abortion under the law and to provide all Kenyans with sufficient information about family planning services, post-abortion care services and sex education constitute violations of the right to information.

The right to information about health is a critical component of reproductive rights; failure to provide such information can threaten the rights to life, health, and autonomy in decision making, and all other reproductive rights of women and girls. The African Charter recognizes that every individual has "the right to receive information" and "the right to education."[1053] The Maputo Protocol specifically includes "the right to have family planning education" and further obligates governments to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas."[1054]

Similarly, CEDAW requires states parties to ensure rural women's "access to adequate health care facilities, including information, counselling and services in family planning"[1055] and obligates states to empower women to "decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights."[1056] The CEDAW Committee has reiterated that "[i]n order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services . . ."[1057]

The CEDAW Committee, in its concluding observations for Kenya, has expressed that it "is deeply concerned . . . that the existing sex education programmes are not sufficient"[1058] The committee recommended that Kenya adopt "measures to increase knowledge of and access to affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children, and access to safe abortion. It further recommends that sex education be widely promoted and targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy . . ."[1059]

The Children's Rights Convention requires states to "develop preventive health care, guidance for parents and family planning education and services."[1060] In the Children's Rights Committee's most recent concluding observations for Kenya, the committee has expressed concern about "the lack of adequate and accessible sex education."[1061] The Children's Rights Committee recommended that the Kenyan government "formulat[e] adolescent-health policies and programmes in the school curriculum, with a particular focus on the prevention of teenage pregnancies [and] unsafe abortions . . . ."[1062]

Additionally, the ESCR Committee "interprets the right to health . . . as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to . . . health-related education and information, including on sexual and reproductive health."[1063] Information accessibility consists of "the right to seek, receive and impart information and ideas concerning health issues."[1064] The ESCR Committee, in its concluding observations for Kenya, expressed concern "about the high number of unsafe clandestine abortions in" Kenya and recommended "raising public awareness and strengthening school education on sexual and reproductive health."[1065]

The Kenyan government violates the right to information in many ways, from failing to provide accurate, comprehensive sexual education in schools; conduct awareness-raising (using complete and accurate information) among the Kenyan public about the existence of safe abortion and post-abortion care services; provide comprehensive, accurate information to women and adolescents seeking family planning services; and train healthcare providers concerning the complete content of the law so they are able to discuss termination as an option with women in cases where it is permitted under the law.

Right to Privacy and Family

The right to privacy is protected by the Civil and Political Rights Covenant[1066] and the Universal Declaration.[1067] The Civil and Political Rights Covenant states that "no one shall be subjected to arbitrary or unlawful interference with his privacy."[1068] The Human Rights Committee has interpreted state obligations under this provision to include a prohibition on all interference with an individual's right to privacy by both public and private actors, to be guaranteed through the creation of legislative frameworks and other state measures that protect individual privacy.[1069]

In *K.L. v. Peru*, a case decided by the Human Rights Committee, K.L. argued that Peru, "in denying her the opportunity to secure medical intervention to terminate the pregnancy, interfered arbitrarily in her private life."[1070] [See Rights Implications of Being Forced to Carry a Pregnancy to Term, p. 72]. The Human Rights Committee, noting that Peru had denied K.L. access to a lawful therapeutic abortion, held that "the refusal to act in accordance with [K.L.'s] decision to terminate her pregnancy was not justified and amounted to a violation of [the right to privacy]."[1071] This analysis is equally applicable in Kenya: when healthcare providers deny women access to safe abortion to preserve their life and health, this constitutes a violation of a woman's right to privacy.

The ESCR Committee also articulates that the right to privacy is an integral component of the right to health.[1072] Its General Comment on the right to the highest attainable standard of health maintains that the freedoms encompassed by the right to health include "the right to control one's health and body, including sexual and reproductive freedom . . ."[1073] Similarly, the CEDAW Committee has stated that "the obligation to *respect rights* requires States parties to refrain from obstructing action taken by women in pursuit of their health goals. . . . States parties should not restrict women's access to health

services . . . on the ground that women do not have the authorization of . . . health authorities . . . ."[1074] In Kenya, the Medical Practitioners and Dentists Board's recommendation that three doctors approve a woman's termination before she is granted access to the procedure violates a woman's right to privacy.

The right to privacy also encompasses the right to confidentiality. The CEDAW Committee has concluded that the right to privacy is essential to realizing a women's right to health, and has required states to ensure that "all health services . . . be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent, and choice."[1075] The right to privacy of Kenyan women is violated when they are not treated with respect and confidentiality when seeking reproductive health services, including post-abortion care. Protection of the right to privacy and confidentiality is an essential element of post-abortion care services: when women believe that healthcare workers will treat their health information confidentially, it encourages them to access these critical health services. When the right to privacy is not properly safeguarded through confidentiality, women are deterred from seeking post-abortion care because they fear stigma, discrimination, and arrest.

With respect to the right to family, the Human Rights Committee has further stated that states are required "to ensure the unity or reunification of families, particularly when their members are separated for political, economic or similar reasons."[1076] The right to family of Kenyan women is violated when they are detained in hospitals for inability to pay following the receipt of post-abortion care and thereby forcefully separated from their families.

Access to Justice: The Right to Redress and Legal Assistance

The lack of adequate complaint procedures and mechanisms and the barriers to seeking redress documented in this report demonstrate clear violations of the right to redress. In addition, women's—particularly poor women's and minors'—lack of access to justice and legal assistance when charged with obtaining an illegal abortion violates the right to legal aid.

Regional and international treaties establish the basic right of individuals to an effective remedy when their human rights have been violated.[1077] The Maputo Protocol specifically recognizes women's right to redress, requiring states to "provide for appropriate remedies to any woman whose rights or freedoms. . . have been violated."[1078] Similarly, the Human Rights Committee has established that "[a] failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant."[1079]

Several international treaties specifically require that an effective remedy exist with respect to violations of the right to health. The CEDAW Committee has stated that in order for states to demonstrate that they "respect, protect and fulfil" a woman's right to health care, they must "ensure that legislation and executive action and policy comply with these three obligations" and also "put in place a system that ensures effective judicial action," indicating that a failure to provide such a remedy would "constitute a violation of article 12 [right to health]."[1080] Similarly, the ESCR Committee has also emphasized that states must establish remedies and ensure that individuals have effective access to these remedies when their right to health is violated.[1081]

With respect to abortion, the Human Rights Committee in *K.L. v. Peru* found that the Peruvian government violated its obligations under the Civil and Political Rights Covenant by failing to provide

K.L. with "an adequate legal remedy"[1082] to contest the medical community's reluctance to provide a therapeutic abortion as permitted under the law.[1083] K.L. had argued that "in Peru there is no administrative remedy which would enable a pregnancy to be terminated on therapeutic grounds, nor any judicial remedy functioning with the speed and efficiency required to enable a woman to require the authorities to guarantee her right to a lawful abortion within the limited period, by virtue of the special circumstance obtaining in such cases."[1084] A similar analysis can be applied to the Kenyan situation, as there is no administrative or judicial procedure in place in Kenya to challenge—in a timely and effective manner—a health care provider's decision to decline a woman's request for a lawful abortion.

The lack of effective complaint procedures and mechanisms for patients who suffer denials of access to legal abortion and post-abortion care and abuses surrounding the provision of these services in Kenyan health facilities constitutes a violation of their right to redress. [See Few Avenues for Redress, p. 64; Limited or No Redress for Abortion-Related Abuses, p. 95]. International law requires the Kenyan government to provide effective redress mechanisms for these violations.

International treaties also require meaningful access to justice for those charged with a criminal offense. The Universal Declaration states that "[e]veryone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence."[1085] The Civil and Political Rights Covenant elaborates on these guarantees, stating,

> *In the determination of any criminal charge against him, everyone shall be entitled to the following minimum guarantees, in full equality: . . . to defend himself in person or through legal assistance of his own choosing; to be informed, if he does not have legal assistance, of this right; and to have legal assistance assigned to him, in any cases where the interests of justice so require, and without payment by him in any such case if he does not have sufficient means to pay for it; . . . [and] not to be compelled to testify against himself or to confess guilt.*[1086]

The African Charter also provides for the "right to defence, including the right to be defended by counsel of his choice."[1087] The African Charter on Children requires states parties to "ensure that every child accused in infringing the penal law . . . shall be afforded legal and other appropriate assistance in the preparation and presentation of his defence."[1088]

In 2009, the Committee against Torture expressed concern about Kenya's legal aid scheme, noting "the persistent problem of access to justice, particularly by those without economic resources."[1089] The Committee urged Kenya "to take all necessary measures to ensure that the lack of resources is not an obstacle to accessing justice" and commented that Kenya "should urgently implement the recently established national legal aid scheme, which could be accompanied by the setting up of an Office of Public Defender."[1090] In addition, in 2007, the Children's Rights Committee noted its regret that, in Kenya, "free legal aid for children is not systematized . . ."[1091] The Children's Rights Committee recommended that Kenya "[e]nsure that persons under 18 years of age in conflict with the law have access to free legal aid as well as to independent and effective complaints mechanisms."[1092]

As documented in this report, many of the women—and children—charged with procuring an illegal abortion in Kenya do not have access to counsel, perhaps due to both a lack of knowledge about their right to counsel and a lack of financial means to afford legal assistance. Regardless of the reason, legal counsel is not being assigned to these women in direct violation of their right to legal assistance. Instead, these women and girls are typically left to defend themselves in court and often simply plead, and are then found, guilty [see Arrest and Prosecution, p. 68].

Recommendations

TO THE GOVERNMENT OF KENYA

To the Executive Branch

- **Publicly acknowledge the importance of reducing unsafe abortion in order to meet Kenya's obligations under the Millennium Development Goals, particularly the goal to reduce maternal mortality.**
- **Support legislative and policy reform to improve access to safe and legal abortion services and quality post-abortion care services. Emphasize that unsafe abortion should be treated as a public health and human rights crisis, not a criminal issue.**

To the Ministry of Medical Services and the Ministry of Public Health and Sanitation

- **Reduce the number of unwanted pregnancies by improving contraceptive access, including addressing shortcomings in post-abortion care family planning.**
  - Ensure that the full range of contraceptive methods is widely and consistently available in all public health facilities.
  - Ensure that providers and adolescents know that adolescents have the right to access contraceptives.
  - Combine post-abortion care services with family planning counseling to improve family planning uptake in government facilities. Ensure that family planning counseling is provided in the same facility as post-abortion care prior to discharge.
- **Remove barriers to emergency contraception (EC), a vital tool in preventing unwanted and unplanned pregnancy.**
  - Clearly address the denial of EC to adolescents and young women as an issue of discrimination.
  - Ensure widespread dissemination of the Division of Reproductive Health's pamphlet "Emergency Contraception: Healthcare Providers Quick Reference Guide" so that providers are not limiting access to EC on the basis of their personal discretion or beliefs. Ensure that all guidelines, manuals, and protocols are updated to reflect that EC can be used up to 120 hours, not 72 hours, after unprotected sex.
  - In light of the Ministry of Health's National Guidelines on the Medical Management of Rape/Sexual Violence (Sexual Violence Guidelines), insist that all health facilities, regardless of their religious affiliation, provide EC to survivors of sexual violence.
- **Remove barriers to seeking post-abortion care services, including by addressing women's fear of legal repercussions and inability to pay.**
  - Ensure that women are aware of their the right to quality post-abortion care at all public and private healthcare facilities and understand that providers are required to offer these services under the law. Ensure that women understand the importance of seeking care early and immediately to avoid greater complications.

- Consider making post-abortion care a free service. In the interim, standardize post-abortion care fees across public health facilities and ensure that this fee structure is public and transparent to all, including by placing the fee on any government-sponsored signs listing fees that are posted at healthcare facilities.
- Publicize and raise awareness through community outreach that the post-abortion care fee can be waived for women who cannot afford it.

- **Remedy equipment and staffing problems that impair the provision of safe abortion and post-abortion care services.**
  - Ensure that all public health facilities have the necessary supplies to provide these services, including sufficient blood supplies and necessary equipment such as gloves, soap, sterilization equipment, functioning and appropriate manual vacuum aspiration (MVA) kits, and misoprostol.
  - Fulfill the government's commitment to ensure that all hospitals, maternities, and health centers have 24-hour services and providers on site who can provide emergency post-abortion care.
- **Develop and disseminate appropriate guidelines to ensure the provision of quality safe abortion services and post-abortion care.**
  - When training on the Sexual Violence Guidelines, include a reference to the guidelines' statement that abortion is an option in cases of rape. Develop implementation guidelines for this provision so providers can appropriately care for women who seek to terminate a pregnancy following rape.
  - Ensure effective dissemination and implementation of the Ministry of Health's Essential Obstetric Care Manual, which has clear abortion and post-abortion care guidelines for providers.
  - Summarize the government's Post-Abortion Care Trainer's Manual into concise and accessible guidelines.
    - Rewrite the section on the law in the manual to clarify the scope and content of the law and policies regarding abortion and the policies governing post-abortion care.
    - Revise the section on pain management to ensure that healthcare providers better understand how to manage pain during the provision of post-abortion care.
  - Ensure development and endorsement of safe abortion guidelines. Ensure dissemination and training on these guidelines.
  - Ensure widespread dissemination and awareness-raising on the Ministry of Health's new policy, clearly evidenced in the Ministry's new National Reproductive Health Curriculum for Service Providers, that allows nurses to be trained in post-abortion care.
  - Ensure the creation and dissemination of a clear referral policy that applies to both public and private/mission healthcare facilities and that covers:
    - Denials of access to legal abortion.
    - Denials of access to contraceptives/EC.
- **Address training gaps around abortion and post-abortion care.**
  - Ensure consistent and widespread comprehensive abortion care training for all providers, including by monitoring training gaps and actively partnering with trainer NGOs to fill in these gaps.

- Ensure that providers are kept abreast of, and trained on, newer and safer technologies in the area of abortion care, such as the use of misoprostol.
- In order to ensure efficient referrals, train community health workers to conduct outreach about the existence and location of post-abortion care.

- **Improve accuracy and availability of data on abortion and post-abortion care to ensure an accurate assessment of, and response to, the scope of the problem of unsafe abortion.**
  - Address providers' fear of reporting accurate abortion-related data by sensitizing Ministry of Health data collectors on the importance of abortion services and of accurate data. Sanction employees who intimidate or harass providers.
  - Ensure that providers who report data accurately receive the necessary additional equipment and supplies for post-abortion care.
  - Address women's fears concerning the use of this data by protecting confidentiality and collecting data in a way that contains no identifying information that could trace the record back to a particular woman.

To the National Council for Population and Development and Relevant Ministries

- **Improve post-abortion care-related indicators or measurements in the Kenya Service Provision Assessment Survey.**
- **Include questions on the effects of, and response to, unwanted and unplanned pregnancies in the Kenya Demographic and Health Survey**.

To the Ministry of Education

- **Reduce unwanted and unplanned pregnancies by improving access to quality sexuality education.**
  - Ensure effective implementation of the Ministry of Education's newly created sexuality education curriculum.
  - Disseminate to schools and teachers the United Nations (UN) Education, Scientific and Cultural Organization's (UNESCO) newly-issued *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers, and health educators* to assist with teaching this subject. (The guidelines, produced by UNESCO in collaboration with the World Health Organization and the UN Children's Fund, among others, are designed, in part, to reduce the need for abortion through sexuality education.)
- **Eliminate discrimination against pregnant schoolgirls and ensure that girls are protected from sexual violence and coercion in educational institutions. With respect to the Ministry's Return to School Policy,**
  - Include an explicit provision prohibiting girls from being expelled from school for having procured an abortion.
  - Ensure that educators are aware of the policy and that it includes girls who have had abortions. Ensure that those who do not comply with the policy face appropriate sanctions.
- **Revise public school educational texts to ensure accurate and evidence-based discussions of reproductive and sexual health. For example, revise the Kenya Certification Secondary Education *Social Education & Ethics Exam Review Book*, which provides inaccurate and biased information concerning abortion.**

To the Ministry of Justice

- **Issue a statement that post-abortion care is a legal service and that women seeking post-abortion care will not be arrested or prosecuted under any circumstances.**
- **Issue a statement, reiterating the Attorney General's position in 1977, that the law on abortion in Kenya incorporates the Commonwealth precedent of Rex v. Bourne and therefore includes an exception to preserve the woman's life, which includes preserving her mental or physical health.**
- **Review existing abortion legislation to ensure that it conforms with Kenya's human rights obligations. Recommend that Parliament remove abortion from the penal code entirely or, at a minimum, to harmonize the law with existing regulations and policies, recommend that Parliament amend the law to introduce explicit exceptions to the legal prohibition, including access to legal abortion in cases of sexual violence and where the physical and mental health of the pregnant woman is threatened.**

To the Attorney General's Office

- **Systematically collect and analyze data on the number of abortion-related cases prosecuted in Kenyan courts, their outcomes, and the characteristics of those prosecuted.**
- **Clarify that post-abortion care is a legal service and that women will not be prosecuted for receiving or seeking post-abortion care under any circumstances.**

To the Kenyan Parliament and Appropriate Ministries

- **Strengthen Kenya's human rights framework.**
  - Create a constitutional framework that recognizes key human rights, such as the right to health and healthcare services.
  - Remove abortion from the penal code entirely or, at a minimum, to harmonize the law with existing regulations and policies, amend the law to introduce explicit exceptions to the legal prohibition, including access to legal abortion in cases of sexual violence and where the physical and mental health of the pregnant woman is threatened.
  - Ratify and domesticate the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol).
  - Domesticate other international conventions already ratified by Kenya, including the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women, and the International Covenant on Economic, Social and Cultural Rights.

TO THE KENYA NATIONAL COMMISSION ON HUMAN RIGHTS

- **Inform and educate the public about reproductive rights, including the right to safe and legal abortion. Publicize treaty monitoring bodies' concluding observations for Kenya pertaining to abortion and post-abortion care.**
- **Recommend to the government that, in conformity with international human rights law and to harmonize the law with existing regulations and policies, it reform the abortion law to, at a minimum, include explicit exceptions for the preservation of a woman's mental and physical health and for rape and incest.**
- **Investigate violations of reproductive rights in healthcare facilities, including denial of access to safe and legal abortion, forced sterilization during post-abortion care, and cruel, inhuman, and degrading treatment in the context of procuring an abortion and obtaining post-abortion care.**

TO ALL PUBLIC AND PRIVATE HEALTHCARE FACILITIES

- **Remove financial barriers and reduce fears of legal repercussions for women seeking post-abortion care services.**
  - Raise awareness among providers and women that post-abortion care is a legal service. Ensure that signs are clearly posted in facilities stating that post-abortion care is a legal service.
  - Ensure fair and transparent payment policies. Include post-abortion care on the list of services and fees placed outside or inside entrances to public and private hospitals.
  - Publicize the fact that the fee for post-abortion care can be waived for women who cannot afford it.
- **Ensure that quality abortion and post-abortion care services are available.**
  - Ensure that protocols and procedures are in place for the provision of safe abortion and post-abortion care, including pain management, and for timely referrals in cases of provider refusals to provide a legal service.
  - Ensure an adequate supply of MVA kits, by including these kits in annual procurement orders and budgets, and that supplies for sterilizing MVA kits are procured and available.
  - Ensure that providers trained to provide abortion and post-abortion care services are on duty 24 hours a day.
  - Ensure coordinated staff transfers so there are always a core set of qualified people capable of offering abortion and post-abortion care services on staff in each facility.
  - Ensure the presence in each facility of healthcare providers who are trained to provide abortion-related care for second-trimester pregnancies.
- **Protect the rights of patients seeking abortion-related services.**
  - Eliminate the practice of detaining patients who cannot pay. This practice is in violation of Kenyan law, the Medical Practitioners and Dentists Board's (Medical Board) Code of Professional Conduct and Discipline (Code of Conduct), and human rights.

- Create effective and formal complaint mechanisms to ensure that patients have redress for violations of their rights in the context of healthcare delivery.
- Ensure that these mechanisms provide effective accountability and remedies for, among other things, verbal abuse in the context of service delivery, delaying tactics in the provision of legal abortion, denials of legal abortion, and demanding bribes to perform a lawful, emergency service such as post-abortion care.
- Establish official rules for confidential and non-biased investigations and initiate disciplinary action against providers who commit abuses, such as those listed above.
- Ensure that patients are aware of both internal complaint mechanisms and the fact that they have recourse to the Medical Board, Clinical Officers Council, and Nursing Council.

TO BODIES OVERSEEING OR REGULATING HEALTHCARE PROFESSIONALS IN KENYA

All bodies

- **Strengthen curricula and training on safe abortion and abortion-related services to ensure the provision of quality care.**
  - Explain the legal and regulatory framework on abortion in Kenya, including the exceptions contained in the Penal Code, the Sexual Violence Guidelines, and the interpretation contained in the Medical Board's Code of Conduct.
    - Highlight providers' ethical obligations to provide emergency contraception and emergency post-abortion care and to refer patients to a qualified provider if they are unable to offer abortion or post-abortion care.
- **Eliminate violations of the rights of women seeking abortion-related services.**
  - Sensitize providers and make clear that mistreatment of patients, including verbal abuse, inadequate pain management, and demanding bribes in return for services, is unacceptable and subject to disciplinary action. Investigate and sanction providers who mistreat patients.
  - Investigate and sanction providers who do not offer services or properly refer patients who seek abortion services as permitted under the law.

Nursing Council

- **Clarify nurses' role in providing abortion-related services and provide the appropriate training to fulfill this role.**
  - Clearly define nurses' scope of practice to include post-abortion care and abortion.
  - Revise the Code of Conduct and Professional Conduct for Nurses to explain that abortion is not wholly prohibited and explicitly include the exceptions that are permitted based on the legal, policy, and regulatory framework. Revise or delete the misleading abortion language under the malpractice column in the list of punishable offenses in the Code of Conduct.
  - Ensure training of the staff and students at the nursing school in Manual Vacuum Aspiration (MVA).
- **Issue an authoritative interpretation of the abortion law for nurses, similar to the Medical Board's, that provides guidance for nurses in performing terminations of pregnancies within the scope of the law.**

Clinical Officers Council

- **Clarify clinical officers' role in providing abortion-related services and provide the appropriate training to fulfill this role.**
  - Clearly define the clinical officers' scope of practice to include post-abortion care and abortion and post-abortion family planning counseling.
  - Ensure that clinical officers have hands-on training in providing abortion-related services, including using MVA, dilation and extraction, and misoprostol.
- **Issue an interpretation of the abortion law, similar to the Medical Board's, that provides guidance for clinical officers in performing terminations of pregnancies within the scope of the law.**
  - Revise the provision on termination of pregnancy in the Code of Professional Conduct for Clinical Officers, which now simply states that termination is not available "on demand," to include a positive statement about when abortion is permitted under the law and when performing the procedure will not subject a provider to disciplinary measures.

Medical Practitioners and Dentists Board

- **Clarify and amend the Code of Conduct provision on termination of pregnancy to ensure greater access to safe abortion services.**
  - Replace the language recommending that the procedure be performed in a hospital with less restrictive language stating that the procedure may be performed at a wider range of qualified healthcare facilities.
  - Replace language implying that the procedure should ideally be performed by a gynecologist with language stating that the procedure can be performed by a "qualified healthcare provider."
  - Make explicit that "health" as mentioned in the provision includes both mental and physical health.
  - Remove the recommendation for consultation with two "senior" colleagues; this unnecessary limitation creates barriers to access given the short supply of doctors in Kenya.
- **Amend the Code of Conduct to introduce disciplinary rules to explicitly address the denial of legal medical care and the obligation to refer in those circumstances.**
- **Streamline the processes for hearing complaints against providers so that they may be heard in a more timely fashion. Make a point to take cases pertaining to delays/denials or abuses in the provision of medically indicated care, namely legal abortion.**

TO MEDICAL SCHOOLS, CLINICAL OFFICER TRAINING SCHOOLS, AND NURSING SCHOOLS

- **Train students to provide respectful, quality post-abortion care, and safe and legal abortions under the existing law and policies.**
  - Ensure that comprehensive post-abortion care and abortion training is an explicitly articulated requirement in each school's curriculum, including informed and non-directive abortion-related counseling, and practical hands-on MVA experience.

- Ensure accurate and comprehensive training on the legal, policy, and regulatory framework surrounding abortion and post-abortion care.
- Ensure training on pain management and misoprostol use for abortion and post-abortion care.
- Ensure wider training on terminating pregnancies and treating abortion-related complications in the second trimester of pregnancy.

TO ASSOCIATIONS OF HEALTHCARE PROFESSIONALS IN KENYA

- **Advocate for increased training and education on abortion and post-abortion care for in-service professionals.**
- **Consider holding education and values clarification workshops on the toll and causes of unsafe abortion with association members.**

TO THE POLICE ADMINISTRATION

- **Sensitize officers on the abortion law and emphasize that post-abortion care is a legal service. Train officers to protect, rather than harass, healthcare providers who offer legitimate services. Ensure that women are not harassed or arrested for obtaining abortions or seeking post-abortion care.**
- **Investigate cases of police impersonators harassing healthcare providers.**

TO THE AFRICAN UNION COMMISSIONER FOR SOCIAL AFFAIRS

- **Urge the Kenyan government to allocate 15% of government expenditure to the health sector, in accordance with the Abuja Declaration of African governments.**

TO UN AND AFRICAN COMMISSION SPECIAL RAPPORTEURS

- **Continue speaking out against violations of reproductive rights as fundamental human rights violations, including lack of access to safe and legal abortion. Continue exposing how other human rights violations, such as sexual violence, contribute to unwanted pregnancy.**
- **Promote respect for reproductive rights defenders by highlighting the importance of their work globally, including in Kenya.**

TO UN TREATY MONITORING BODIES AND THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS

- **Use Kenya's periodic reporting to issue strong concluding observations and recommendations in order to reinforce Kenya's obligation to protect the rights of women seeking reproductive healthcare services, including safe abortion and quality post-abortion care services, and to**

provide redress and remedies for violations of these rights.

- Encourage the ratification and implementation of key regional and human rights treaties that protect reproductive rights, including the right to safe and legal abortion services.

TO THE INTERNATIONAL DONOR COMMUNITY

- Support advocacy efforts to protect women's reproductive rights, including efforts to improve access to safe and legal abortion services and quality post-abortion care. Support initiatives to document and seek redress for reproductive rights violations.
- Assist the Kenyan government with establishing mechanisms for preventing and monitoring abuses in the provision of reproductive healthcare, including abortion and post-abortion care services.
- Increase funding for post-abortion care programs, including training and equipment purchasing.

TO UNITED STATES STATE DEPARTMENT AND OFFICE OF GLOBAL WOMEN'S ISSUES, AND THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

- Include information on unsafe abortion and access to post-abortion care in the State Department's Country Reports on Human Rights.
- Continue disseminating information about the fact that the Mexico City Policy (which restricted organizations receiving USAID funding from advocating for access to abortion) has been rescinded. Support efforts to strengthen information exchange, capacity building, and the technical capacity necessary to implement the repeal of the Mexico City Policy.
- Take steps to mitigate the harms caused by the Mexico City Policy by increasing funding to strengthen local capacity to provide reproductive health services and information to women, and to advocate for reproductive rights, including the right to safe abortion.

Endnotes

1 Interview with Evelyne, Sarah's mother, Kibera, July 11, 2009.
2 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
3 World Health Organization, Preventing Unsafe Abortion (2010) *available at* http://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/index.html.
4 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
5 *Id.*; focus group discussion with unnamed participants, Mombasa, Aug. 4, 2009.
6 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
7 Interview with Emmaculate, Community Organizer in Kibera, Nairobi, June 30, 2009.
8 Interview with Grace, Dandora Phase I, July 14, 2009; interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.
9 Interview with Nurse/Administrator, Maternity Hospital, Nairobi, Nov. 16, 2006 (name withheld); interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.
10 Focus group discussion with unnamed participants, Gembe, July 7, 2009; focus group discussion with unnamed participants, Mombasa, Aug. 4, 2009.
11 Focus group discussion with unnamed participants, Gembe, July 7, 2009; focus group discussion with unnamed participants, Mombasa, Aug. 4, 2009.
12 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld); focus group discussion with unnamed participants, Mombasa, Aug. 4, 2009.
13 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld); interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
14 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
15 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
16 Focus group discussion with unnamed participants, Gembe, July 7, 2009.
17 David A. Grimes et al, *Unsafe abortion: the preventable pandemic*, 368 The Lancet at 1908 (Nov. 2006) [hereinafter *The preventable pandemic*].
18 Hailemichael Gebreselassie, *The magnitude of abortion complications in Kenya*, 112 BJOG: an International Journal of Obstetrics and Gynaecology at 1229 (Sept. 2005) [hereinafter *The magnitude of abortion complications in Kenya*].
19 *The preventable pandemic* at 1910.
20 *The magnitude of abortion complications in Kenya* at 1232.
21 *The preventable pandemic* at 1911.
22 *Id.* at 1911-12.
23 *The magnitude of abortion complications in Kenya* at 1229.
24 *The preventable pandemic* at 1911; *The magnitude of abortion complications in Kenya* at 1229.
25 Abdhalah Kasiira Ziraba et al., *Maternal mortality in the informal settlements of Nairobi city: what do we know?*, 6(6) Reproductive Health Journal (April 2009) *available at* www.reproductive-health-journal.com/content/6/1/6 (last visited Feb. 1, 2010) [hereinafter Ziraba, *Maternal Mortality: what do we know?*].
26 *The preventable pandemic* at 1908.
27 Interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
28 Interview with Dr. Willis Badia, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 9, 2009.
29 Interview with Nurse, Mbita, July 6, 2009 (name withheld).
30 *The preventable pandemic* at 1910.
31 *Id.*
32 Ministry of Health (Kenya), Kenya National Post Abortion Care Curriculum: Trainer's Manual §§1, 26 (2003) [hereinafter *MOH Post Abortion Care Trainer's Manual*].
33 World Health Organization, Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA, and the World Bank 25 (2007) *available at* http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf (according to this publication, Kenya has 7,700 maternal deaths/yearhttp://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf at 25; according to the Ministry of Health and the Kenya Demographic and Health Survey 1998, 35% of pregnancy related mortality is attributable to unsafe abortion).
34 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya at 25 (2004).
35 Ziraba, *Maternal mortality: what do we know?*
36 *The preventable pandemic* at 1914.
37 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya at ix, 21 (2004).
38 *Id.* at 21 (2004).
39 *The magnitude of abortion complications in Kenya* at 1233.
40 *Id.*
41 E. B. Wamwana, *Socio-demographic characteristics of patients admitted with gynaecological emergency conditions at the provincial general hospital, Kakamega, Kenya*, 83(12) East African Medical Journal at 665 (Dec. 2006) [hereinafter Wamwana, *Kakamega study*].
42 *Id.* at 661.
43 *The preventable pandemic* at 1914.
44 *MOH Post Abortion Care Trainer's Manual* at §§1, 27 (2003).
45 Ruling of Judge K.H. Rawal, *Republic of Kenya v. Dr. John Nyamu and others* (Criminal Case No. 81 of 2004), June 14, 2005, Kenya—High Court at 15 [hereinafter *Kenya v. Nyamu*].
46 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
47 Interview with Marion Kibathi, Nurse, Nairobi, Aug. 6, 2009.
48 Interview with Dr. John Nyamu, Obstetrician-Gynecologist, Reproductive Health Services, Nairobi, June 30, 2009.
49 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
50 *Id.*
51 Interview with Dr. John Nyamu, Obstetrician-Gynecologist, Reproductive Health Services, Nairobi, June 30, 2009.
52 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
53 Interview with Dr. John Nyamu, Obstetrician-Gynecologist, Reproductive Health Services, Nairobi, June 30, 2009.
54 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
55 Interview with Marion Kibathi, Nurse, Nairobi, Aug. 6, 2009.
56 *Id.*
57 *Id.*
58 *Kenya v. Nyamu* at 15.
59 *Id.* at 18.
60 *Id.* at 3.
61 *Id.* at 10.
62 *Id.* at 17.
63 Interview with Marion Kibathi, Nurse, Nairobi, Aug. 6, 2009; Chief Magistrates Criminal Case No. 1294 of 2005 (June 14, 2005).
64 Criminal Procedure Code, §123(1), Cap. 75 of the Laws of Kenya *available at* www.kenyalaw.org/kenyalaw/klr_app/frames.php; interview with Marion Kibathi, Nurse, Nairobi, Aug. 6, 2009.
65 The charges were withdrawn one month after they were "preferred" on July 12, 2005. *See Reproductive Health Services, Dr. John Muchai Nyamu and others v. The Hon. Attorney General* (Civil Case No. 610 of 2006), Civil Complaint, June 13, 2006, Kenya –High Court at para. 9(m) [hereinafter *Nyamu v. Attorney General*].
66 Interview with Dr. John Nyamu, Obstetrician-Gynecologist, Reproductive Health Services, Nairobi, June 30, 2009.
67 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
68 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
69 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
70 Interview with Marion Kibathi, Nurse, Nairobi, Aug. 6, 2009.
71 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
72 *Nyamu v. Attorney General* at para. 13 (a)-(d).
73 *Id.* at para. 9

74 *Id*.

75 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009; interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

76 The Penal Code at §159, Cap. 63 of the Laws of Kenya, (Revised ed. 2009) [hereinafter The Penal Code].

77 The Penal Code at §158, Cap. 63.

78 The Medical Practitioners and Dentists Board, The Code of Professional Conduct and Discipline at 16, MPDB Circular No. 4/79 (5th ed. May, 2003) [hereinafter Medical Practitioners and Dentists Code of Conduct].

79 The Penal Code at §160, Cap. 63.

80 The Penal Code at §214, Cap. 63.

81 *Kenya v. Nyamu* at 15.

82 The Penal Code at §240, Cap. 63 (stating that "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.").

83 See Rebecca Cook and Bernard Dickens, *Abortion Laws in African Commonwealth Countries*, 25(2) Journal of African Law, (1981); *MOH Post Abortion Care Trainer's Manual* at §1, 36 (2003).

84 *Rex v. Bourne* [1939] 1 K.B. 687; [1938] 3 All E.R. 615.

85 The Penal Code at §158, Cap. 63.

86 The Penal Code at §159, Cap. 63.

87 The Penal Code at §160, Cap. 63.

88 The Penal Code at §214, Cap. 63.

89 The Penal Code at §240, Cap. 63.

90 *Rex v. Bourne* [1939] 1 K.B. 687; [1938] 3 All E.R. 615, at 692, 693 [hereinafter *Rex v. Bourne*].

91 Medical Practitioners and Dentists Code of Conduct at 16.

92 Ministry of Health (Kenya), Medical Management of Rape/Sexual Violence Guidelines, at.8, (1st ed. 2004) *available at* http://www.drh.go.ke/documents/Guidelines_gender.pdf (last visited Jan. 26, 2010) [hereinafter MOH Management of Rape/Sexual Violence].

93 *Rex v. Bourne* at 691.

94 *Rex v. Bourne* at 694.

95 Rebecca Cook and Bernard Dickens, *Abortion Laws in African Commonwealth Countries*, 25(2) Journal of African Law, (1981) at 60-62.

96 *Mehar Singh Bansel v. R* [1959] E.A.L.R. 813. *See* Rebecca Cook and Bernard Dickens, *Abortion Laws in African Commonwealth Countries,* 25(2) Journal of African Law, (1981) at 61: "…in *Mehar Singh Bansel v. R* the East African Court of Appeal referred to the case [of *Rex v. Bourne*] as reflecting prevailing law."

97 Rebecca Cook, Bernard Dickens and Farouk Muslim, *Options for Reform of Abortion Law in Kenya*, citing *Mehar Singh Bansel v. R* [1959] E.A.L.R. 813 at p.832.

98 *Id*.

99 Letter from Attorney General to Commonwealth Secretariat, Legal Division (April 26, 1977), Ref. No. 5067/12 II(98).

100 Letter (questionnaire response enclosed) from Attorney General to Commonwealth Secretariat, Legal Division (Oct. 7, 1976), Ref. No. 5057/12 II(58).

101 Medical Practitioners and Dentists Code of Conduct at 16.

102 MOH Management of Rape/Sexual Violence at 8.

103 Interview with David Wambuku, Education Officer, and Frederick Ochieno, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009; interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009; interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009; interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009 ("There was only dissemination of the guidelines done, not training on the guidelines."); interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009; interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.

104 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.

105 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

106 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

107 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

108 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.

109 Martin Eccles, Jeremy Grimshaw, Richard Grol, Allen Hutchinson, and Steven Woolf, *Potential benefits, limitations, and harms of clinical guidelines*, 318(7182) British Medical Journal, 527-530 (Feb. 1999).

110 *Id*.

111 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009; interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.

112 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009; interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.

113 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

114 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

115 *See generally* Medical Practitioners and Dentists Act, Chapter 253 (1978); Medical Practitioners and Dentists Code of Conduct. *See also* interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009; interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

116 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009; interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

117 Medical Practitioners and Dentists Code of Conduct at 16.

118 National Coordinating Agency for Population and Development (NCAPD) (Kenya), Ministry of Health, Central Bureau of Statistics, *Kenya Service Provision Assessment Survey 2004*, at 13, *available at* www.measuredhs.com/pubs/pdf/SPA8/02Chapter2.pdf (last visited Feb. 15, 2010) [hereinafter 2004 KSPAS].

119 *Id*.at 21.

120 Central Intelligence Agency, The World Factbook: Kenya, *available at* https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html (last visited Jan. 28, 2010).

121 Neeru Gupta et al., *Uses of population census data for monitoring geographical imbalance in the health workforce: snapshots from three developing countries*, 2(11) International Journal for Equity in Health (2003). Citing a study looking at the inequality of the spatial distribution of health workers found that distribution inequalities of health workers were not only high in Kenya, but highest among health professionals (Gini coefficient of 0.497), then nursing/midwifery personnel (0.277) and finally other health associate professionals (0.263). The Gini coefficient is a mathematical measure of inequality in income or wealth.

122 Interview with Consultant Obstetrician and Gynecologist, New Nyanza Provincial Hospital, Kisumu, July 28, 2009 (name withheld).

123 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009; *see also* 2004 KSPAS at 112.

124 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

125 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009; interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

126 World Health Organization, *Mid-level health-care providers are a safe alternative to doctors for first-trimester abortions in developing countries* [WHO/RHR/HRP/08.15] (2008), *available at* http://www.who.int/reproductivehealth/publications/unsafe_abortion/rhr_hrp_08_15/en/index.html (last visited Jan. 28, 2010).

127 Interview with Dr. Margaret Meme, Program Manager, Gender and Reproductive Rights and Dr. Annie Gituto, Program Officer, Maternal Newborn Health, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 6, 2009.

128 Interview with Dr. Willis Badia, Obstetrician and Gynecologist, Private Practitioner and Consultant at New Nyanza Provincial Hospital, Kisumu, July 9, 2009; interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld); interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009; interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009; interview with Consultant Obstetrician and Gynecologist, New Nyanza Provincial Hospital, Kisumu, July 28, 2009 (name withheld).

129 Interview with Dr. John Nyamu, Gynecologist with private practice in Nairobi, June 30, 2009.

130 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.

131 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and Obstetrician and Gynecologist, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

132 Statistic provided by Administrative Assistant, Medical Practitioners and Dentists Board, Nairobi, Nov. 2, 2009.

133 Frank Njenga, *Focus on psychiatry in East Africa*, (181) The British Journal of Psychiatry, 354-359 (2002), *available at* http://bjp.rcpsych.org/cgi/content/full/181/4/354 (last visited Jan. 28, 2010).

134 *MOH Post Abortion Care Trainer's Manual* at xvii.

135 *Id.* at §1, 24.

136 *Id.* at §§1,33 and 1,36.

137 *Id.* at §1,36.

138 *Id.* at §1,36.

139 Interview with Nurse, Nyalenda, Kisumu, July 9, 2009 (name withheld); interview with Nurse, Mbita, July 6, 2009 (name withheld); interview with Nurse, Mbita, July 6, 2009 (name withheld); interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

140 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.

141 The Nurses Act, § 9(1)(d), Cap. 257 of the Laws of Kenya, (Revised ed. 1985).

142 Interview with David Wambuku and Frederick Ochieno, Educational Officers in the Education Department, Nursing Council of Kenya, Nairobi, July 20, 2009.

143 *Id.*

144 *Id.*

145 Nursing Council of Kenya, Code of Ethics and Professional Conduct for Nurses at 21 (Mar. 2006).

146 *See Id.*

147 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and Obstetrician and Gynecologist, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

148 Kenya Medical Training College, Introduction to Clinical Medicine (2008) *available at* http://www.kmtc.ac.ke/Academic-Courses/Diploma-Courses/Clinical-Medicine (last visited Feb. 9, 2010).

149 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009. See generally, Clinical Officers (Training, Registration and Licensing) Act, Cap. 260 of the Laws of Kenya (Revised ed. 1990).

150 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

151 *Id.*

152 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009; *see also* interview with Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, Oct. 29, 2009.

153 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

154 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

155 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009; interview with Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, Oct. 29, 2009.

156 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

157 Interview with Oscar Oyata, Clinical Officer, Kisumu District Hospital, Kisumu, July 27, 2009.

158 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld).

159 Interview with Dr. John Nyamu, Gynecologist with private practice in Nairobi, June 30, 2009.

160 Interview with Dr. Juliana Otieno, Chief Administrator, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

161 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, June 5, 2009.

162 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.

163 *Id.*

164 *MOH Post Abortion Care Trainer's Manual* at §§1, 29.

165 *Id.* at §§1, 37 (2003).

166 *Id.* at §§1, 37 (2003).

167 Ministry of Health (Kenya), Essential Obstetric Care Manual (Third ed. 2006), at 68-79.

168 Ministry of Health (Kenya), Norms and Standards for Health Service Delivery: Reversing the trends, the Second National Health Sector Strategic Plan of Kenya (2006), *available at* http://www.hsrs.health.go.ke/publications.htm (for a further description of the different levels of healthcare facilities in Kenya see pages 2-7) [hereinafter MOH Reversing the Trends].

169 2004 KSPAS at 21.

170 MOH Reversing the Trends at 25.

171 2004 KSPAS at 21.

172 MOH Reversing the Trends at 25.

173 *Id.*

174 Ministry of Health (Kenya) (Division of Reproductive Health) and Ministry of Planning and National Coordinating Agency for Population and Development (Ministry of Planning and National Development), Adolescent Reproductive Health and Development Policy Plan of Action 12 (2005-2015) *available at* http://www.drh.go.ke/documents/Adolescent%20RH%20Plan%202005-2015.pdf.

175 *Id.*

176 Ministry of Health (Kenya), National Reproductive Health Policy: Enhancing Reproductive Health Status for All Kenyans at 9 (2007).

177 *Id.* at 12.

178 Ministry of Health (Kenya) (Division of Reproductive Health), Kenya National Reproductive Health Curriculum for Service Providers (2006).

179 *Id.* at foreword ix.

180 *Id.*

181 *Id.* at foreword 18 (2006).

182 National Joint Steering Committee for Maternal Health (Kenya) (Coordinators:

Kenya Obstetrician and Gynecologists Society and National Nurses Association of Kenya), Standards for Maternal Care in Kenya (2002). *available at* http://www.drh.go.ke/documents/STDs%20for%20maternal%20care.pdf.

183 *Id*. at iv, 2.
184 *Id*. at vii.
185 *Id*. at 1.
186 *Id*. at 6.
187 *Id*. at 1.
188 *Id*. at 6.
189 *Id*. at 1, 4.
190 *Id*. at 26.
191 *Id*.
192 *Id*.
193 *Id*.
194 *Id*.
195 *Id*.
196 *Id*.
197 *Id*.
198 *Id*. at 27.
199 *Id*.
200 *Id*.
201 Central Bureau of Statistics, 2003 Kenya Demographic and Health Survey 110 (2004) [hereinafter 2003 KDHS].
202 Tony Johnston, Population Communication Africa, The Sexual Abuse of Kenyan Women and Girls: A Briefing Book 6, 14 (2003).
203 Renson Mnyamwezi, *NGO decries rise in rape cases*, The Standard, April 23, 2009, at 9.
204 *Id*.
205 2003 KDHS at 244.
206 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).
207 *Id*. at 63.
208 *Id*. at 62 and Table 4.2 (United States Agency for International Development, 2008).
209 Joy Wanja, *Teenage Sex Study Shock for Parents*, Daily Nation, Oct. 13, 2009.
210 Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, Daily Nation, Nov. 1, 2009 *available at* http://allafrica.com/stories/200911020402.html (last visited Feb. 8, 2010).
211 *Id*.
212 *Id*.
213 Commission of Inquiry into the Post Election Violence, Final Report (CIPEV) at 265 (Oct. 15, 2008) *available at* http://www.communication.go.ke/Documents/CIPEV_FINAL_REPORT.pdf (last visited Feb. 4, 2010) [hereinafter Post Election Violence Commission, Final Report].
214 *Id*. at 247.
215 *Id*. at 247-8.
216 *Id*.
217 MOH Management of Rape/Sexual Violence at 2.
218 Stephanie Holmes, *Gang Rape Spirals in Violent Kenya*, BBC News, Jan. 23, 2008, *available at* http://news.bbc.co.uk/2/hi/africa/7204680.stm (last visited Feb. 5, 2010) [hereinafter Holmes, *Gang Rape Spirals*]; *Rape on the Rise in Post-election Violence*, IRIN, Jan. 2, 2008, *available at* http://www.irinnews.org/Report.aspx?ReportId=76068 (last visited Feb. 5, 2010) [hereinafter *Rape on the Rise in Post-election Violence*].
219 Holmes, *Gang Rape Spirals*; *Rape on the Rise in Post-election Violence*.
220 Post Election Violence Commission, Final Report at 246.
221 Women's Commission for Refugee Women and Children, *Reproductive Health Coordination Gap, Services Ad hoc: Minimum Initial Service Package (MISP) Assessment in Kenya* 14 (2008).
222 MOH Management of Rape/Sexual Violence Guidelines at 2.
223 Post Election Violence Commission, Final Report at 264.
224 Center for Reproductive Rights and Federation of Women Lawyers – Kenya, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities* 23 (2007)[hereinafter *Failure to Deliver*] (Interview with Joseph M. Oyongo, Quality Assurance Officer – Christian Health Association of Kenya, Nov. 20, 2006; Interview with Margaret Ogola, National Executive Secretary, and other members of the Catholic Secretariat – Kenya Episcopal Conference, Nairobi, Apr. 10, 2007); interview with Dr. Ayisi, National Executive Secretary, Kenya Episcopal Conference, Catholic Secretariat, Nairobi, Aug. 13, 2009.
225 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
226 MOH Management of Rape/Sexual Violence at 2.
227 *See* World Health Organization (WHO), *Family Planning: A Global Handbook for Providers* 45, 49 (2007), *available at* http://info.k4health.org/globalhandbook/handbook.pdf (last visited Feb. 4, 2010). *See also* WHO, *Fact sheet No. 244: Emergency Contraception* (Oct. 2005), *available at* http://www.who.int/mediacentre/factsheets/fs244/en/index.html (last visited Feb. 4, 2010).
228 Division of Reproductive Health, Ministry of Health (Kenya), Emergency Contraception: Health Care Providers Quick Reference Guide at 4 (2008).
229 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 9, 2009; interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009; interview with Louis Machogu, Programs Pharmacists, Family Health Options Kenya, Nairobi, July 1, 2009; interview with Stephen Kimatu, Head, Medicines Information Department, Pharamcy and Poisons Board, Nariobi, July 20, 2009; interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
230 MOH Management of Rape/Sexual Violence at 8.
231 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
232 Kenya National Bureau of Statistics et al., 2008-2009 Kenya Demographic and Health Survey: Preliminary Report 14 (June 2009).
233 2003 KDHS at 106.
234 *Failure to Deliver* at 18; Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, Inter Press Service (Latin America), May 18, 2009; *see also* National Coordinating Agency for Population and Development, the Ministry of Health, and the Central Bureau of Statistics, The 2004 Kenya Service Provision Assessment Survey—Family Planning Key Findings at 5 *available at* www.measuredhs.com/pubs/pdf/SR176/SR176.pdf (last visited Feb. 4, 2010).
235 *Id*.
236 Geoffrey Kamadi, *Population Threat to Vision 2030*, Daily Nation, May 13, 2009 [hereinafter Kamadi, *Population Threat to Vision 2030*].
237 Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, Inter Press Service (Latin America), May 18, 2009.
238 *Id*.
239 *Id*. *See also* Mike Mwaniki, *Shortage of Contraceptives Looms*, Daily Nation, Aug. 4, 2009 [hereinafter Mwaniki, *Shortage of Contraceptives*].
240 Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, Inter Press Service (Latin America), May 18, 2009. *See also* Mike Mwaniki, *Shortage of Contraceptives Looms*, Daily Nation, Aug. 4, 2009.
241 Elizabeth Mwai, *Country Has a Billion Condoms in Stock*, The Standard, May 9, 2008, *available at* http://allafrica.com/stories/200805081081.html (last visited Feb. 4, 2010).
242 *Id*.
243 Geoffrey Kamadi, *Population Threat to Vision 2030*, Daily Nation, May 13, 2009.
244 National Coordinating Agency for Population and Development, the Ministry of Health, and the Central Bureau of Statistics, The 2004 Kenya Service Provision Assessment Survey—Family Planning Key Findings *available at* www.measuredhs.com/pubs/pdf/SR176/SR176.pdf (last visited Feb. 4, 2010) 9.
245 Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, Inter Press Service (Latin America), May 18, 2009.
246 *Id*.
247 Susan Anyangu, *Nyong'o Decries Limited Access to Contraceptives*, The Standard, Aug. 4, 2009.
248 *Id*.
249 Centre for the Study of Adolescence, Down the Drain: Counting the Costs of Teenage Pregnancy and School Drop Out in Kenya 31 (2008) [hereinafter Centre for the Study of Adolescence, Down the Drain].
250 Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, Inter Press Service, Oct. 27, 2009, *available at* http://allafrica.com/stories/200910271243.html (last visited Feb. 4, 2010).
251 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.

252 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
253 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
254 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
255 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
256 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.
257 Jill Keesbury et al., *Mainstreaming Emergency Contraception (EC) in Kenya: Final Project Report* 29 (Population Council, Nairobi, 2009) [hereinafter *Mainstreaming Emergency Contraception*].
258 *Id*. The Population Council, a non-profit organization focused on reproductive health issues, tracked the sales of four major brands of emergency contraceptives in the private-sector from 2007 to 2009. It documented an increase from 45,870 units sold in Kenya in Oct. 2007 to 138,150 units sold in June 2009.
259 *Id*. at 20.
260 *Id*.
261 *Id*.
262 *Id*.
263 *Id*. at 30.
264 *Id*. at 12.
265 Interview with Jeremiah Gaunye, Chief Pharmacist, Suba District Hospital, Suba, July 8, 2009.
266 Division of Reproductive Health, Ministry of Health (Kenya), Emergency Contraception: Health Care Providers Quick Reference Guide (2008) 3.
267 *Id*. at 4.
268 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
269 Interview with Louis Machogu, Programs Pharmacists, Family Health Options Kenya, Nairobi, July 1, 2009.
270 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
271 Interview with Jeremiah Gaunye, Chief Pharmacist, Suba District Hospital, Sindo, July 8, 2009.
272 Interview with Stephen Kimatu, Head, Medicines Information Department, Pharmacy and Poisons Board, Nariobi, July 20, 2009; focus group discussion with unnamed participant, Kibera, July 11, 2009.
273 Interview with Stephen Kimatu, Head, Medicines Information Department, Pharmacy and Poisons Board, Nariobi, July 20, 2009.
274 *Id*.
275 Interview with Louis Machogu, Programs Pharmacists, Family Health Options Kenya, Nairobi, July 1, 2009; Interview with Stephen Kimatu, Head, Medicines Information Department, Pharamcy and Poisons Board, Nariobi, July 20, 2009.
276 2003 KDHS at 95, Table 6.5.
277 Centre for the Study of Adolescence, Down the Drain at 31.
278 Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, Inter Press Service, Oct. 27, 2009, *available at* http://allafrica.com/stories/200910271243.html (last visited Feb. 4, 2010) ("At St Georges, a public school, aside from a project funded by a non-governmental organisation, there is no sexual education on the curriculum.").
279 *Id*.
280 Sammy Cheboi, *Sex Education Lacking, Says Health Official*, The Daily Nation, Sept. 23, 2009, *available at* http://allafrica.com/stories/200909230822.html (last visited Feb. 5, 2010).
281 *Id*.
282 Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, Inter Press Service, Oct. 27, 2009, *available at* http://allafrica.com/stories/200910271243.html (last visited Feb. 4, 2010).
283 *Id*.
284 Joyce Mulama, *Stopping Pregnancy From Being the End of the Educational Road*, Inter Press Service, July 28, 2006.
285 Centre for the Study of Adolescence, Down the Drain at 28.
286 2003 KDHS at 82.
287 2003 KDHS at 84.
288 *Mainstreaming Emergency Contraception* 24. For example, even the BBC has reported that regularly using emergency contraceptives can lead to infertility and increase the risk of cancer.
289 2003 KDHS at 77.
290 2003 KDHS at 79.
291 2003 KDHS at 80.
292 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
293 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
294 Interview with Grace, Dandora Phase I, July 14, 2009.
295 *Id*.
296 Interview with Emmaculate, Community Organizer, Kibera, June 30, 2009; interview with Evelyne, Kibera, July 11, 2009.
297 *See* World Health Organization (WHO), *Family Planning: A Global Handbook for Providers* 13, 18 (2007), *available at* http://info.k4health.org/globalhandbook/handbook.pdf (last visited Feb. 8, 2010).
298 Interview with Emmaculate, Community Organizer, Kibera, July 11, 2009.
299 A "majority of urban Kenyans" live in slum-like conditions in informal settlements. The Centre on Housing Rights and Evictions, *Kenya: Right to Housing and Water, Article 11(1)* at 2 (2007). Over 222,000 Kenyans are considered to be "internally displaced persons," residing in makeshift and often unsafe camps, unable to return to their homes due to violence or other factors. United States Agency for International Development, *Kenya: Complex Emergency Fact Sheet #2 (FY 2008)* at 1 (2008).
300 Centre for the Study of Adolescence, Down the Drain at 31.
301 *Post-violence Sex Work Boom*, IRIN, July 9, 2008, *available at* http://plusnews.org/report.aspx?ReportId=79166 (last visited Feb. 5, 2010).
302 *Id*.
303 *Id*.
304 Muchiri Karanja, *Sex for Food in Nyeri Slums,* The Daily Nation, Oct. 13, 2009, *available at* http://allafrica.com/stories/200910131171.html (last visited Feb. 5, 2010).
305 Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, Inter Press Service, Oct. 27, 2009, *available at* http://allafrica.com/stories/200910271243.html (last visited Feb. 4, 2010).
306 *Kenya's Tourist Coast Attracts Youths, Sex Workers*, afrol News, Mar. 9, 2008, *available at* http://afrol.com/printable_article/24664 (last visited Feb. 5, 2010).
307 *Id*.
308 Committee on the Rights of the Child, Concluding Observations, Kenya, para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).
309 2003 KDHS at 62.
310 Centre for the Study of Adolescence, Down the Drain at 28 (2008).
311 Kwamboka Oyaro, *Teenage Mothers Denied Education*, Inter Press Service, May 23, 2008, *available at* http://ipsnews.net/africa/nota.asp?idnews=42487 (last visited Feb. 5, 2010). *See also* Centre for the Study of Adolescence, Down the Drain at 8.
312 Centre for the Study of Adolescence, Down the Drain at 11, citing to the Central Bureau of Statistics, Economic Survey 2007.
313 Kwamboka Oyaro, *Teenage Mothers Denied Education*, Inter Press Service, May 23, 2008, *available at* http://ipsnews.net/africa/nota.asp?idnews=42487 (last visited Feb. 5, 2010).
314 Centre for the Study of Adolescence, Down the Drain at 46-47.
315 *Id*. at 48.
316 *Id*.
317 Peter Mutai, *Lone Girl in Class After 24 Pregnant Students Drop Out*, The Standard, Mar. 9, 2009, *available at* http://www.eastandard.net/news/InsidePage.php?id=1144023081&cid=4& (last visited Feb. 5, 2010).
318 Anthony Kitimo, *Pregnancy Causes 28 to Drop Out of School*, Daily Nation, Oct. 6, 2009; Anthony Kitimo, *Probe Order as 28 Girls Quit School*, Daily Nation, Oct. 6, 2009.
319 Centre for the Study of Adolescence, Down the Drain at 45.
320 *Id*. at 44; Kwamboka Oyaro, *Teenage Mothers Denied Education*, Inter Press Service, May 23, 2008, *available at* http://ipsnews.net/africa/nota.asp?idnews=42487 (last visited Feb. 5, 2010).
321 Centre for the Study of Adolescence, Down the Drain at 8, 44.
322 Ellen M. H. Mitchell et al., *Social scripts and stark realities: Kenyan adolescents' abortion discourse*, 8(6) Culture, Health and Sexuality 524 (Dec. 2006).
323 *Id*. at 518 (Dec. 2006), citing Odaga and Heneveld 1995.
324 *Id*., citing Okumu et al., 1994 and Murray et al., 2003.

325 *Top KCPE Pupil Dies after Abortion*, East African Standard, Jan. 6, 2005.
326 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
327 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
328 Joyce Mulama, *Stopping Pregnancy From Being the End of the Educational Road*, Inter Press Service, July 28, 2006.
329 Interview with Grace, Dandora Phase I, July 14, 2009.
330 The Penal Code at § 240, Cap. 63.
331 Medical Practitioners and Dentists Code of Conduct at 16.
332 MOH Management of Rape/Sexual Violence at 2.
333 Rebecca Cook and Bernard Dickens, *Abortion Laws in African Commonwealth Countries*, 25(2) Journal of African Law, (1981) at 61.
334 Hon. Marth Karua, *Abortion Under the Kenyan Law: Legal Status of Abortion and Judicial Interpretation* as cited in Kenya Medical Association, *Maternal Deaths and Unsafe Abortion in Kenya* at 46 (Report of a workshop held at Panarific Hotel, Nairobi, Nov. 4th – 6th, 2004) *available at* http://www.kma.co.ke/downloads/maternal/maternal-deaths.pdf (last visited Feb. 3, 2010).
335 Ellen M. H. Mitchell et al., *Social scripts and stark realities: Kenyan adolescents' abortion discourse*, 8(6) Culture, Health and Sexuality at 517 (Dec. 2006).
336 *Id*., citing Mitchell et al., *TeenWeb Nairobi: Results of a web-based project to survey and educate students about health* (2004). Chapel Hill, NC, Ipas.
337 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
338 Interviews with Grace, Chastity, Elizabeth, Ida, Martha, Dandora Phase I, July 14, 2009; focus group discussion with unnamed participant, Kibera, July 11, 2009.
339 Focus group discussion with unnamed participants, Kibera, July 11, 2009.
340 Focus group discussion with unnamed participants, Kibera, July 11, 2009.
341 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
342 Focus group discussion with unnamed participant, Mombasa, Aug. 3, 2009.
343 Ellen M. H. Mitchell et al., *Social scripts and stark realities: Kenyan adolescents' abortion discourse*, 8(6) Culture, Health and Sexuality at 517 (Dec. 2006).
344 *Id*.
345 T*he preventable pandemic* at 1908.
346 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
347 Interview with Martha, Dandora Phase I, July 14, 2009.
348 Interview with Milka O'ron'y, Community Health Assistant, Patient Support Center, Mbita Subdistrict Hospital, Mbita, July 7, 2009.
349 *Id*.
350 Interview with Charity, Kisumu, July 10, 2009.
351 Institute of Economic Affairs – Kenya, Profile of Women's Socio-economic Status in Kenya at 18-19 (2008), *available at* http://www.ieakenya.or.ke/documents/Profiling%20Women%20in%20Kenya.pdf (last visited Feb. 2, 2010).
352 United Nations Development Program, Human Development Report 2009 Data: Kenya, *available at* http://hdrstats.undp.org/en/buildtables/rc_report.cfm (last visited Feb. 2, 2010).
353 *See* interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Chastity, Dandora Phase I, July 14, 2009.
354 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009. In contrast, the Fees Guidelines for Medical/Dental Practitioners, issued by the MPDB, lists the minimum fee for termination of pregnancy as ranging from 10,000 – 20,000 Kenyan shillings [$132-263], depending on whether the provider is performing menstrual regulation, or whether the pregnancy is before or after 12 weeks. The maximum fee for termination ranges from 20,000 – 40,000 Kenyan shillings [$263-526], again varying with the stage of pregnancy. The Medical Practitioners and Dentists Board, Fees Guidelines for Medical/Dental Practitioners at 34 (2nd ed., 2006).
355 Interview with Dr. John Nyamu, Gynecologist with private practice in Nairobi, June 30, 2009.
356 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld); conversation with unnamed woman, Kisumu, July 8, 2009.
357 Interview with Clinical Officer at public hospital, Kisumu, July 27, 2009
358 Interview with Nurse, Nyalenda, Kisumu, July 9, 2009 (name withheld).
359 Interview with Nurse-Midwife, Manyatta, Kisumu, July 9, 2009 (name withheld).
360 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
361 Focus group discussion with unnamed participant, Rusinga Island, July 7, 2009.
362 Interview with Nurse, Nyalenda, Kisumu, July 9, 2009 (name withheld).
363 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
364 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009. *See also* interview with Nurse, Nyalenda, Kisumu, July 9, 2009 (name withheld).
365 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.
366 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
367 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.
368 Kisumu Medical and Educational Trust Training Handout, on file with the Center for Reproductive Rights.
369 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
370 Interview with Clinical Officer, Private Clinic, Mbita, July 6, 2009 (name withheld).
371 Neither Mbita Subdistrict Hospital nor Suba District Hospital had gynecologists on staff at the time of interviews. *See* interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009; Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
372 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.
373 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
374 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.
375 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
376 Interview with Nurse-Midwife, Manyatta, Kisumu, July 9, 2009 (name withheld).
377 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.
378 Manpreet Rehal, *All I want is Justice, not Revenge*, Daily Nation, Nov. 10, 2009.
379 *Id*.
380 MOH Management of Rape/Sexual Violence at 2.
381 Manpreet Rehal, *All I want is Justice, not Revenge*, Daily Nation, Nov. 10, 2009.
382 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
383 Interview with Rape Trauma Counselor, Kenyatta National Hospital, Nairobi, Oct. 30, 2009 (name withheld).
384 Interview with Carol Waiganjo, Program Officer, Coalition on Violence Against Women, Nairobi, Oct. 28, 2009.
385 Interview with Rape Trauma Counselor, Kenyatta National Hospital, Nairobi, Oct. 30, 2009 (name withheld).
386 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 20 (2004).
387 World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems 21, 31 (2003) *available at* http://whqlibdoc.who.int/publications/2003/9241590343.pdf.
388 *Id*. at 30.
389 See, *Failure to Deliver* at 67-72 (discussing complaint mechanisms).
390 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
391 Pacific Institute for Women's Health and Center for the Study of Adolescence, Community level dynamics of unsafe

abortion in western Kenya and opportunities for prevention at 11 (1999); interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

392 Pacific Institute for Women's Health and Center for the Study of Adolescence, Community level dynamics of unsafe abortion in western Kenya and opportunities for prevention at 11 (1999).

393 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

394 Fed Makana, Op-Ed./Letters, *Shut Down Clinics run by Quacks*, Daily Nation, Sept. 7, 2009: In Sept. 2009, the government did shut down illegal clinics and arrest "quacks with fake academic credentials posing as doctors" in Nairobi and Thika. "The mushrooming private clinics tell it all. The rising number of abortion related deaths have been attributed to these quacks."

395 Interview with Dr. Willis Badia, Obstetrician-Gynecologist, Kisumu, July 9, 2009.

396 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

397 Kenya Institute for Public Policy Research Analysis (KIPPRA), *A Review of the Regulatory Framework for Private Healthcare Services in Kenya*, KIPPRA Discussion Paper No. 35 at 60 (2004).

398 Interview with Dr. Chris Wagaiyu, Chair, and Stella Mwihaki, Legal Advisor-Kenya Medical Practitioners and Dentists Board, Nairobi, Mar. 13, 2007; see *Failure to Deliver* at 70.

399 *Failure to Deliver* at 71(2007).

400 Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson – Kenya Medical Association, Nov. 24, 2006; see *Failure to Deliver* at 71 (2007).

401 Kenya Institute for Public Policy Research Analysis (KIPPRA), *A Review of the Regulatory Framework for Private Healthcare Services in Kenya*, KIPPRA Discussion Paper No. 53 at 63 (2004).

402 *Id*. at 56-57.

403 *Failure to Deliver* at 67.

404 Interview with Dr. Stephen Ochiel, Obstetrician-Gynaecologist and Chairperson – Kenya Medical Association, Nairobi, Nov. 24, 2009; see *Failure to Deliver* at 68.

405 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.

406 *Id*.

407 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.

408 *Id*.

409 Medical Practitioners and Dentists Code of Conduct at Appendix II: The Internal Code of Medical Ethics—1949, at 32.

410 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.

411 *See* International Federation of Gynecology and Obstetrics, Resolution on "Conscientious Objection", adopted by the FIGO General Assembly on Nov. 7, 2006 *available at* http://www.figo.org/projects/conscientious [hereinafter FIGO Resolution] ; World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems (2003) 66 *available at* http://whqlibdoc.who.int/publications/2003/9241590343.pdf [hereinafter WHO Safe Abortion Guidance].

412 *See* FIGO Resolution ("[T]o behave ethically, practitioners shall ... 2. Refer patients who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services"); WHO Safe Abortion Guidance ("Health workers have… an ethical obligation to follow professional ethical codes, which usually require health professionals to refer women to skilled colleagues who are not, in principle, opposed to termination of pregnancy allowed by law.").

413 FIGO Resolution ("[T]o behave ethically, practitioners shall ... 4. In emergency situations, provide care regardless of practitioners' personal objections."); International Federation of Gynecology and Obstetrics, Code of Ethics: FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights A(5) *available at* http://www.figo.org/Codeofethics (last visited Feb. 4, 2010) ("Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay."); and World Medical Association, Declaration on the Rights of the Patient 1(f) (2005) *available at* http://www.wma.net/en/30publications/10policies/l4/index.html (last Feb. 4, 2010) ("The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.").

414 World Health Organization, Department of Reproductive Health and Research, Complications of abortion: technical and managerial guidelines for prevention and treatment 95 (1995) *available at* http://whqlibdoc.who.int/publications/1995/9241544694.pdf (last visited Feb. 5, 2010).

415 WHO Safe Abortion Guidance 66.

416 FIGO Resolution.

417 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

418 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009; interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

419 Interview with Dr. Zahida Qureshi, University of Nairobi/KNH, Nairobi, Aug. 10, 2009; interview with Dr. Njoroge Waithaka, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.

420 Interview with Dr. Zahida Qureshi, University of Nairobi/KNH, Nairobi, Aug. 10, 2009; interview with Dr. Njoroge Waithaka, Kenyatta National Hospital, Aug. 11, 2009; interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.

421 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.

422 Interview with Dr. Zahida Qureshi, University of Nairobi/KNH, Nairobi, Aug. 10, 2009.

423 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

424 Interview with Dr. Njoroge Waithaka, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.

425 *Id*.

426 *Id*.

427 Statistic provided by Administrative Assistant, MPDB, Nairobi, Nov. 2, 2009.

428 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.

429 Interview with Nurse, Nyalenda, Kisumu, July 9, 2009 (name withheld).

430 Interview with Elizabeth, Dandora Phase I, July 14, 2009.

431 Interview with Emmaculate, Community Organizer in Kibera, Nairobi, June 30, 2009.

432 Interview with Evelyne, Kibera, July 11, 2009.

433 Interview with reproductive rights researcher, Nairobi, Nov. 5, 2009 (name withheld).

434 *Id*.

435 Interview with Evelyne, Kibera, July 11, 2009.

436 Interview with reproductive rights researcher, Nairobi, Nov. 5, 2009 (name withheld).

437 Interview with Emmaculate, Community Organizer in Kibera, Nairobi, June 30, 2009.

438 Interview with reproductive rights researcher, Nairobi, Nov. 5, 2009 (name withheld).

439 *Id*.; email correspondence with reproductive rights researcher, Jan. 7, 2010 (name withheld).

440 Interview with reproductive rights researcher, Nairobi, Nov. 5, 2009 (name withheld).

441 *Id*.

442 *Id*.

443 *Id*.

444 Interview with Ida, Dandora Phase I, July 14, 2009.

445 *Id*.

446 Interview with reproductive rights researcher, Nairobi, Nov. 5, 2009 (name withheld).

447 *MOH Post Abortion Care Trainer's Manual* at §§1, 32 (2003).

448 Interview with Carol Waiganjo, Program Officer, Coalition on Violence Against Women, Nairobi, Oct. 28, 2009.

449 Interview with rape trauma counselor, Kenyatta National Hospital, Nairobi, Oct. 30, 2009 (name withheld).

450 Interview with Carol Waiganjo, Program Officer, Coalition on Violence Against Women, Nairobi, Oct. 28, 2009.

451 Interview with rape trauma counselor, Kenyatta National Hospital, Nairobi, Oct. 30, 2009 (name withheld).

452 *African Platform for Action, Fifth Regional Conference on Women,* Dakar, Senegal,

Nov. 16-23, 1994, para. 42, U.N. Doc. E/CN.6/1995/5/Add.2 (1995).

453 CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, para. 21, U.N. Doc. A/49/38 (1994) [hereinafter CEDAW General Recommendation No. 21].

454 CEDAW Committee, *General Recommendation 24: Women and health*, para. 28 U.N. Doc. A/54/38 (1999).

455 CEDAW General Recommendation No. 21 at para. 21.

456 Andrew Gumbel, *Colombian ruling breaks seal on abortion rights in Latin America*, The Independent, May 13, 2006, *available at* http://www.independent.co.uk/news/world/americas/colombian-ruling-breaks-seal-on-abortion-rights-in-latin-america-477939.html (last visited Feb. 3, 2010).

457 Hernandez Mora, *La ley llega tarde para Marta*, El Mundo, May 13, 2006, available at http://www.womenslinkworldwide.org/pdf_programs/es_prog_rr_col_articles_4.pdf; *See also*, Women's Link Worldwide, Marta's Story, As performed by Jane Krakowski at International Women's Day event, co-sponsored by International Women's Health Coalition and *Glamour Magazine*: The Story of My Body (Mar. 8, 2007) *available at* http://www.iwhc.org/index.php?option=com_content&task=view&id=2138&Itemid=824.

458 Human Rights Committee, *General Comment 28: Equality of rights between men and women*, para. 11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).

459 *Tysiac v. Poland*, application no. 5410/03, §§7-18, European Court of Human Rights 2007-IV [hereinafter *Tysiac v. Poland*].

460 *Tysiac v. Poland*, at §18.

461 *Tysiac v. Poland* at §109.

462 This standard was recently developed further at the level of the Council of Europe. See Parliamentary Assembly of the Council of Europe, *Resolution 1607 (2008) Access to safe and legal abortion in Europe*, adopted by the Assembly April 16, 2008 (15th Sitting) *available at* http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm (last visited Feb. 3, 2010).

463 *Tysiac v. Poland*, at §116.

464 *Tysiac v. Poland* at §117.

465 *Tysiac v. Poland* at §§117, 118.

466 *Tysiac v. Poland* at §§148, 152.

467 *K.L. v. Peru,* communication no. 1153/2003, §§2,1, 2.3, 2.6, United Nations Human Rights Committee (2005) [hereinafter *K.L. v. Peru*].

468 *K.L. v. Peru* at §6.3.

469 *K.L. v. Peru* at §6.3.

470 *Paulina del Carmen Ramírez Jacinto v. Mexico*, petition no. 161-02, Inter-American Commission on Human Rights (2007).

471 Ziraba, *Maternal mortality: what do we know?*

472 Interview with Evelyne, Kibera, July 11, 2009.

473 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009.

474 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

475 Interview with Grace, Dandora Phase I, July 14, 2009.

476 Interview with Emmaculate, Community Organizer in Kibera, Nairobi, June 30, 2009.

477 National Joint Steering Committee for Maternal Health (Kenya) (Coordinators: Kenya Obstetrician and Gynecologists Society and National Nurses Association of Kenya), Standards for Maternal Care in Kenya at 27 (2002) *available at* http://www.drh.go.ke/documents/STDs%20for%20maternal%20care.pdf (last visited Jan. 29, 2010).

478 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.

479 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

480 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

481 *MOH Post Abortion Care Trainer's Manual* at 1-37.

482 *Id*.

483 Interview with Nurse/Administrator, Maternity Hospital, Nairobi, June 20, 2009 (name withheld).

484 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.

485 Interview with Ida, Dandora Phase I, July 14, 2009.

486 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

487 *MOH Post Abortion Care Trainer's Manual* at 1-32 (2003).

488 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.

489 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.

490 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.

491 Focus group discussion with unnamed participant, Kibera, July 11, 2009.

492 Focus group discussion with unnamed participant, Kibera, July 11, 2009.

493 Focus group discussion with unnamed participant, Kibera, July 11, 2009.

494 *MOH Post Abortion Care Trainer's Manual* at 1-29.

495 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld).

496 Interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, July 28, 2009.

497 Interview with Nurse with private clinic, Mbita, July 6, 2009 (name withheld).

498 Interview with Nurse with private clinic, Mbita, July 6, 2009 (name withheld).

499 Interview with Nurse-Midwife/Clinic Owner, Dandora Phase I, July 3, 2009 (name withheld).

500 Interview with Grace, Dandora Phase I, July 14, 2009.

501 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.

502 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

503 Community Postabortion Care Project (COMMPAC) in Nakuru District, Kenya: Summary Report, Phase I: July 2005-Sept. 2006, at 12 (USAID, 2007).

504 *Id*.

505 Abdhalah K Ziraba, et al., *The state of emergency obstetric care services in Nairobi informal settlements and environs: Results from a maternity health facility survey*, 9 (46) BMC Health Services Research at 5 & 7 (2009).

506 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.

507 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld); interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009; interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009; interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009; interview with Nurse, Kisumu, July 9, 2009 (name withheld); interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009; focus group discussion with unnamed participant, Kibera, July 11, 2009.

508 National Joint Steering Committee for Maternal Health (Kenya) (Coordinators: Kenya Obstetrician and Gynecologists Society and National Nurses Association of Kenya), Standards for Maternal Care in Kenya at 26 (2002) *available at* http://www.drh.go.ke/documents/STDs%20for%20maternal%20care.pdf .

509 *MOH Post Abortion Care Trainer's Manual* at 1-30.

510 *See* Poverty Section; *See also* Hon. Martha Karua, *Abortion under the Kenyan Law: Legal Status of Abortion and Judicial Interpretation* in Report of a Workshop on Maternal Deaths and Unsafe Abortion in Kenya, Nov. 2004, at 46.

511 Interview with Evelyne, Kibera, July 11, 2009.

512 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.

513 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

514 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

515 Interview with Dr. Willis Badia, Obstetrician-Gynecologist, New Nyanza Provincial Hospital, Kisumu, July 9, 2009.

516 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.
517 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
518 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009 and Nov. 3, 2009.
519 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.
520 Interview with Dr. Stephen Ochiel, Obstetrician-Gynecologist, University of Nairobi, June 19, 2009.
521 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Dr. Jennifer Othigo, Reproductive Health Advisor for Coast Province, Division of Reproductive Health, Mombasa, Aug. 4, 2009; interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
522 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
523 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
524 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
525 Focus group discussion with unnamed participant, Gembe, July 7, 2009.
526 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
527 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.
528 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
529 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009; interview with Dr. Jennifer Othigo, Reproductive Health Advisor for Coast Province, Division of Reproductive Health, Mombasa, Aug. 4, 2009; interview with Damarice Otieno, Nurse, Suba District Hospital, Sindo, July 8, 2009; interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
530 Interview with Nurse with private clinic, Mbita, July 6, 2009 (name withheld).
531 Interview with Nurse, Mbita, July 6, 2009 (name withheld).
532 Interview with Mercy Mathai, Nurse, Private Practice, Nairobi, June 30, 2009.
533 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009.
534 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld).
535 Interview with Dr. Jean Kaggia, Obstetrician-Gynecologist, Upper Hill Medical Centre, Nairobi, Aug. 12, 2009.
536 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.
537 Community Postabortion Care Project (COMMPAC) in Nakuru District, Kenya: Summary Report, Phase I: July 2005-Sept. 2006, at x (USAID, 2007).
538 Interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.
539 Interview with Nurse, Mbita, July 6, 2009 (name withheld).
540 Interview with Grace, Dandora Phase I, July 14, 2009.
541 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009; interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
542 *Failure to Deliver* at 54, citing Ricardo Bitrán & Ursula Giedion, Waivers and Exemptions for Health Services in Developing Countries 72 (Social Protection Unit, The World Bank, Social Protection Discussion Paper Series No. 0308, Mar. 2003), *available at* http://www-wds.worldbank.org (last visited Feb. 8, 2010).
543 *Failure to Deliver* at 52.
544 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
545 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
546 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
547 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
548 *Failure to Deliver* at 54.
549 *Id.* at 52-53.
550 Edmund Sander, *In Kenya, patients held hostage to medical bills*, Los Angeles Times, June 27, 2009, *available at* http://articles.latimes.com/2009/jun/28/world/fg-kenya-healthcare28.
551 *Failure to Deliver* at 56-58.
552 *Id.* at 57.
553 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
554 Interview with Dr. Qureshi, Professor of OB/GYN, University of Nairobi/KNH, Aug. 10, 2009.
555 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
556 *Id.*
557 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
558 Edmund Sander, *In Kenya, patients held hostage to medical bills*, Los Angeles Times, June 27, 2009, *available at* http://articles.latimes.com/2009/jun/28/world/fg-kenya-healthcare28.
559 Interview with Nurse, National Nurses Association of Kenya and Kenyatta National Hospital, Nairobi, Nov. 5, 2009(name withheld).
560 *Id.*
561 *Id.*
562 For abusive spouses and relatives refusing to pay user fees, see *Failure to Deliver* at 58.
563 Interview with Nurse, National Nurses Association of Kenya and Kenyatta National Hospital, Nairobi, Nov. 5, 2009(name withheld).
564 Interview with Nurse, National Nurses Association of Kenya and Kenyatta National Hospital, Nairobi, Nov. 5, 2009 (name withheld).
565 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
566 *Id.*
567 *Id.*
568 Edmund Sander, *In Kenya, patients held hostage to medical bills*, Los Angeles Times, June 27, 2009, *available at* http://articles.latimes.com/2009/jun/28/world/fg-kenya-healthcare28 [hereinafter *Patients held hostage to medical bills*].
569 Medical Practitioners and Dentists Code of Conduct, Chapter V, 7(iii) at 30.
570 *Patients held hostage to medical bills*, citing Njoroge Baiya.
571 2004 KSPAS, *Overview of the health system in Kenya* at 33.
572 *Id.*
573 *MOH Post Abortion Care Trainer's Manual* at §§1, 30, citing Ministry of Health (Kenya), Reproductive Health Guidelines and Standards for Service Providers (1997).
574 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.
575 *MOH Post Abortion Care Trainer's Manual* at §§1, 37 (2003).
576 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
577 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
578 *Id.*
579 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.
580 *Id.*
581 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.
582 Interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Francisca Bahati, Kenya Registered Community Health Nurse and Family Planning, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.

583 Interview with Nurse, Kisumu, July 9, 2009 (name withheld); Interview with Nurse, Mbita, July 6, 2009 (name withheld).
584 Interview with Nurse, Mbita, July 6, 2009 (name withheld).
585 *Id*.
586 Ministry of Health (Kenya) (Division of Reproductive Health), Kenya National Reproductive Health Curriculum for Service Providers (2006).
587 *Id*. *at foreword*, ix.
588 *Id*. at18.
589 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
590 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
591 *Id*.
592 *Id*.
593 Interview with Mercy Mathai, Nurse, Private Practice, Nairobi, June 30, 2009.
594 Focus group discussion with unnamed participant, Kibera, July 11, 2009.
595 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
596 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
597 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
598 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
599 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009.
600 *Id*.
601 *Id*
602 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
603 *Id*
604 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
605 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
606 Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007; Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007; *see Failure to Deliver* at 25.
607 Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007; *see Failure to Deliver* at 25.
608 Focus group discussion with unnamed participant, Mombasa, Aug. 4, 2009.
609 *MOH Post Abortion Care Trainer's Manual* at §§1, 37.
610 *Id*. at §§1, 29.
611 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
612 *Id*.
613 *Id*.
614 Interview with Damarice Otieno, Nurse, Suba District Hospital & private practice, Sindo, July 8, 2009.
615 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
616 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
617 Interview with David Wambuku, Education Officer, and Frederick Ochieno, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009.
618 *See* World Health Organization, Complications of Abortion: Technical and managerial guidelines for prevention and treatment 42-43 (1995).
619 *See* World Health Organization, Complications of Abortion: Technical and managerial guidelines for prevention and treatment 55-56 (1995). (On page 55 the guidelines specify that "[w]hile general, regional and local anaesthesia have all been used in abortion care, local anaesthesia should suffice for the majority of uterine evacuation procedures.").
620 Word Health Organization, Clinical management of abortion complications: a practical guide 53 (1994).
621 World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems 34 (2003), *available at* http://whqlibdoc.who.int/publications/2003/9241590343.pdf. *See also* Word Health Organization, Clinical management of abortion complications: a practical guide, Annex 4, 61 (1994), *available at* http://whqlibdoc.who.int/hq/1994/WHO_FHE_MSM_94.1.pdf.
622 *MOH Post Abortion Care Trainer's Manual* at §§5, 1.
623 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 26 (2004).
624 *The magnitude of abortion complications in Kenya* at 1234.
625 *Id*.
626 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.
627 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
628 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
629 2004 KSPAS: Family Planning Key Findings, Appendix B, Table A-6.37 288 (2006).
630 E-mail from Dr. Nehemiah Kimathi, Technical Advisor, Safe Motherhood, International Planned Parenthood Federation Kenya ("I have talked to the Chief Pharmacist ministry of health (Dr C K Koske) who says that the drugs [analgesics] are available at all levels of care – dispensaries, health centres and hospitals.") to Reproductive Health and Rights Alliance, Feb. 3, 2010 (on file with the Center for Reproductive Rights).
631 *The magnitude of abortion complications in Kenya* at 1234; Interview with Dr. Joachim Osur, Reproductive Health Expert, Nairobi, Nov. 2, 2009; interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld).
632 Interview with Dr. Joachim Osur, Reproductive Health Expert, Nairobi, Nov. 2, 2009.
633 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
634 Interview with Dr. Joachim Osur, Reproductive Health Expert, Nairobi, Nov. 2, 2009.
635 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009; interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
636 Interview with Dr. Joachim Osur, Reproductive Health Expert, Nairobi, Nov. 2, 2009.
637 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
638 Id.
639 *The magnitude of abortion complications in Kenya* at 1234.
640 Interview with Dr. Joachim Osur, Reproductive Health Expert, Nairobi, Nov. 2, 2009.
641 *Id*.
642 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
643 *Id*.
644 *Id*.
645 Kenya Institute for Public Policy Research Analysis (KIPPRA), *A Review of the Regulatory Framework for Private Healthcare Services in Kenya*, KIPPRA Discussion Paper No. 35 at 60 (2004).
646 Interview with official with close ties to the Medical Board, Nairobi, July 1, 2009 (name withheld).
647 Interview with Dr. Zahida Qureshi, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 10, 2009.
648 *Id*.
649 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.
650 Ministry of Health (Kenya), Implementation Plan for National Reproductive Health Strategy: 1999-2003 (Dec. 1998) 6, 9. Note: According to the Division of Reproductive Health, this strategy remains in place as of Oct. 2009. There has been no new strategy issued to address the period from 2004 to the present. (Conversation with Resource Librarian, Division of Reproductive Health, Nairobi, Oct. 30, 2009).

651 All taken from World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems 29-30 (2003), *available at* http://whqlibdoc.who.int/publications/2003/9241590343.pdf (last visited Feb. 4, 2010).

652 Charlotte E. Hord, Making safe abortion accessible: A practical guide for advocates, Ipas 9 (2001) *available at* http://www.ipas.org/Publications/asset_upload_file495_3176.pdf (last visited Feb. 4, 2010).

653 World Health Organization, Education material for teachers of midwifery: midwifery education modules—Managing incomplete abortion 115 (2nd ed., 2008).

654 *Id.*

655 Charlotte E. Hord, Making safe abortion accessible: A practical guide for advocates, Ipas 9 (2001), *available at* http://www.ipas.org/Publications/asset_upload_file495_3176.pdf (last visited Feb. 4, 2010).

656 World Health Organization, Clinical Management of Abortion Complications: A Practical Guide (1994) 19, available at http://whqlibdoc.who.int/hq/1994/WHO_FHE_MSM_94.1.pdf.

657 World Health Organization, Educational materials for teachers of midwifery: midwifery education modules—Managing incomplete abortion 62 (2nd ed., 2008), *available at* http://whqlibdoc.who.int/publications/2008/9789241546669_3_eng.pdf (last visited Feb. 4, 2010).

658 Charlotte E. Hord, Making safe abortion accessible: A practical guide for advocates, Ipas 9 (2001) *available at* http://www.ipas.org/Publications/asset_upload_file495_3176.pdf (last visited Feb. 4, 2010).

659 *Id.*

660 Ipas, Medical Abortion (internet factsheet), *available at* http://www.ipas.org/topics/medical_abortion.aspx (last visited Feb. 4, 2010).

661 Ipas, Misoprostol and Medical Abortion in Africa 1 (2009) *available at* www.ipas.org/Publications/asset_upload_file683_4512.pdf (last visited Feb. 4, 2010).

662 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

663 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

664 Kenya Medical Training College, Introduction to Clinical Medicine (2008) *available at* http://www.kmtc.ac.ke/Academic-Courses/Diploma-Courses/Clinical-Medicine (last visited Feb. 9, 2010).

665 *Failure to Deliver* at 70, citing Interview with Clinical Officers Council official, Nairobi, Feb. 7, 2007.

666 2004 KSPAS at 112.

667 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

668 *Id.*

669 *Id.*

670 2004 KSPAS at 21, Table 2.3.

671 Clinical Officers Council, Clinical Officers Training Curriculum, CMS 364: Reproductive Health, Module IV, Unit 1: Operative Obstetrics/Gynaecology, 104-105 (no date provided; on file with the Center for Reproductive Rights).

672 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

673 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

674 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

675 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld); interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009. The 2008 National Reproductive Health Training Plan makes reference to this, stating that clinical officers are required to "conduct manual vacuum aspiration … in some hospitals only." Ministry of Health (Kenya), *National Reproductive Health Training Plan: 2007-2012* at 10 (May 2008).

676 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

677 *Id.*

678 *Id.*

679 *Id.*

680 Clinical Officers Council, Clinical Officers Training Curriculum, CMS 364: Reproductive Health, Module IV, Unit 1: Operative Obstetrics/Gynaecology, 104-105 (no date provided; on file with the Center for Reproductive Rights).

681 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

682 Interview with Micah K. Kisoo, Registrar, Clinical Officers Council and Chief Clinical Officer, Ministry of Medical Services, and Manaseh Bocha, Deputy Chief Clinical Officer, Ministry of Medical Services, Nairobi, July 22, 2009.

683 *Id.*

684 *Id.*

685 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

686 World Health Organization, Complications of Unsafe Abortion: technical and managerial guidelines for prevention and treatment (2005) 49 *available at* http://whqlibdoc.who.int/publications/1995/9241544694.pdf (last visited Feb. 9, 2010). Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009. *See also* interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

687 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

688 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 17 (2004).

689 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

690 *See* 2004 KSPAS 21, Table 2.3.

691 Interview with David Wambuku, Education Officer, and Frederick Ochieno, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009.

692 *Id.*

693 *Id.*

694 *Id.*

695 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

696 *Id.*

697 *Id.*

698 *Id.*

699 *Id.*

700 *Id.*

701 Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.

702 MOH Reversing the Trends at 9, 29.

703 Ministry of Health (Kenya), National Reproductive Health Curriculum for Service Providers ix, 18 (2006).

704 Interview with David Wambuku, Education Officer, and Frederick Ochieno, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009.

705 *Id.*

706 Interview with Nurse-midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).

707 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.

708 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.

709 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

710 *Id.*

711 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

712 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.

713 World Health Organization, World Health Organization Statistics 2009: Health workforce, infrastructure, essential medicines: Kenya (2009) 98 *available at* http://www.who.int/whosis/whostat/EN_WHS09_Full.pdf (last visited Feb. 9, 2010).

714 The Penal Code at § 240, Cap. 63.

715 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.

716 Committee on Economic, Social, and Cultural Rights, Report of the Special Rapporteur, Paul Hunt, U.N. Doc. E/CN.4/2004/49, para.30 (Feb. 16, 2004).

717 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Nairobi, Nov. 3, 2009.

718 Interview with Manaseh Bocha, Deputy Chief Clinical Officer, Focal Person for Reproductive Health, Ministry of Health, Oct. 29, 2009.

719 Interview with David Wambuku, Education Officer, and Frederick Ochieno, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009.

720 Interview with Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, School of Nursing, Nairobi, Aug. 5, 2009.

721 *Id.*

722 American Psychological Association Task Force on Mental Health and Abortion, Report of the Task Force on Mental Health and Abortion 4 (2008). *See also* Nada Stotland, *The myth of the abortion trauma syndrome*, 268 (15) Journal of the American Medical Association (1992) 2078-2079.

723 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

724 *Id.*

725 Interview with Milka O'ron'y, Community Health Assistant, Patient Support Center, Mbita Subdistrict Hospital, Mbita, July 7, 2009.

726 *Id.*

727 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.

728 *Id.*

729 2004 KSPAS at Table A-6.43.1, 294 (Nov. 2005).

730 *Id. at* Appendix B, Table A-6.43.2, 295.

731 *Id. at* Appendix B, Table A-7.5, 301.

732 Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.

733 Interview with Nurse/Administrator, Maternity Hospital, Nairobi, June 20, 2009 (name withheld).

734 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.

735 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.

736 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.

737 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

738 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

739 *Id.*

740 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.

741 *Id.*

742 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

743 Ipas, National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya vi (2004), Foreword by Dr. James Nyikal, Director of Medical Services, Ministry of Health (Kenya).

744 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya Foreword at v (2004).

745 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

746 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

747 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.

748 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.

749 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009 ("…there are no technical guidelines on how to provide these [PAC and abortion] services. The only wall charts I've seen are the ones IPAS gives out."); interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.

750 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009 ("They [the MOH] don't have anything – we should urge them to have PAC guidelines.)

751 Ministry of Health (Kenya), Essential Obstetric Care Manual: for Health Service Providers in Kenya 68-79 (3rd ed. Jan. 2006).

752 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

753 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

754 *Id.*

755 *MOH Post Abortion Care Trainer's Manual.*

756 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

757 2004 KSPAS at 148. Drawing upon the UN Process Indicators for Emergency Obstetric Care to measure "certain types of obstetric services that were understood to have a direct bearing on maternal outcomes, including mortality and morbidity," the 2004 KSPAS looked at five critical services considered essential to basic emergency obstetric care. These services included the administration of parenteral antibiotics and parenteral oxytocic drugs and the removal of retained products of conception, all of which can be critical to post-abortion care. *Id.* at 146.

758 2004 KSPAS at 148.

759 *Id.* Comprehensive emergency obstetric services are defined by the 2004 KSPAS as basic services plus the capacity to perform Cesarean delivery and blood transfusions, the latter sometimes being a critical aspect of PAC. 2004 KSPAS at 147.

760 *Id.* at 33.

761 *Id.*

762 Ipas, *available at* http://www.ipas.org/Products.aspx (last visited Feb. 9, 2010).

763 Ipas, Processing Ipas MVA Plus® Aspirators and Adapters (2007), *available at* http://www.ipas.org/Publications/asset_upload_file72_3241.pdf (last visited Feb. 9, 2010).

764 2004 KSPAS at 32, with hospitals (37%), maternities (36%), clinics (39%) and health centres (23%) having varying water supply capacities. Overall, 26% of all Kenyan healthcare facilities had a regular water supply, however capacity was disproportionately distributed – Nairobi (53%), Rift Valley (36%) and Central (32%) Provinces had the highest capacity and Western (9%), Nyanza (7%) and Coast (4%) had the lowest.

765 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

766 2004 KSPAS at Appendix B, Table A-6.30, 281.

767 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.

768 The ACQUIRE Project/Engender Health, Community Postabortion Care Project (COMMPAC) in Nakuru District, Kenya: Summary Report, Phase I: July 2005-Sept. 2006 (2007) 13.

769 *Id.*

770 A 2005 study on abortion complications in Kenya found that of 809 women requiring PAC in a sample of 54 district hospitals, 14% of those presenting with high or moderate-severity abortion complications and 11% of women with second trimester complications received blood. These figures do not account for those women who needed blood products and did not receive them. *The magnitude of abortion complications in Kenya* at 1229, 1233.

771 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

772 2004 KSPAS at Appendix B, Table A-6.36, 287 (Nov. 2005). Maternities (46%) and hospitals (89%) are most likely to have the capacity to offer blood transfusion

services. The 2004 KSPAS also notes that this capacity has *declined* since 1999, when 65% of maternities provided blood transfusion services. 2004 KSPAS at 140.

773 Dr. Zahida Qureshi, Professor of OB/GYN, University of Nairobi/Kenyatta National Hospital, Nairobi, Aug. 10, 2009.

774 *Id*.

775 Japan International Cooperation Agency and The Ministry of Health, Kenya, Summary Report: The Study on Blood Transfusion System in Kenya (Jan. 2002) 6.

776 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009; interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

777 Interview with Dr. Zahida Qureshi, Professor of OB/GYN, University of Nairobi/Kenyatta National Hospital, Nairobi, Aug. 10, 2009.

778 2004 KSPAS at SurveyAppendix B, Table A-6.36, 287.

779 *Id*.

780 *Id*.

781 *Id*.

782 *Id*.

783 2004 KSPAS at 14.For example, "[f] acilities in Coast province are most likely to have a vacuum aspirator (59 percent), compared with facilities in Rift Valley and Eastern provinces (6 percent and 5 percent, respectively)."

784 Abdhalah K Ziraba et al., *The state of emergency obstetric care services in Nairobi informal settlements and environs: Results from a maternity health facility survey*, 9(46) BMC Health Services Research 2 (2009).

785 *Id*. at 4.

786 *Id*.

787 *Id*. at 5.

788 USAID, Maternal and Neonatal Program Effort: MNPI 2005, Kenya: Results from the 2005 survey, at 3, *available at* http://www.policyproject.com/pubs/MNPI/MNPI2005/2005Kenya.pdf. The MNPI was conducted by the Futures Group International and funded by the U.S. Agency for International Development (USAID) through the MEASURE Evaluation Project. The study collected data from reproductive health experts in 50 developing countries. These experts rated 81 aspects of maternal and neonatal health services in their country and the results were compiled into an index. Possible scores ranged from 0-100, with 100 being the highest. Rural women's access to PAC was rated at 27/100 while urban women's access was rated at 70/100. *See also* Rodolfo A. Bulatao, and John A. Ross. 2002. *Rating Maternal and Neonatal Health Services in Developing Countries*, 80 Bulletin of the World Health Organization at 721–727; John A. Ross et al., *The Maternal and Neonatal Programme Effort Index (MNPI)* 6(10) Tropical Medicine and International Health at 787–798.

789 Ministry of Health (Kenya), Implementation Plan for National Reproductive Health Strategy: 1999-2003 (Dec. 1998) 38.

790 2004 KSPAS at Appendix B, Table A-6.36, 287 (Nov. 2005).

791 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

792 Interview with Francisca Bahati, Nurse, Coast Provincial General Hospital, Mombasa, Aug. 3, 2009.

793 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Aug. 12, 2009.

794 Interview with Damarice Otieno, Nurse, Suba District Hospital, Sindo, July 8, 2009.

795 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

796 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

797 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, July 27, 2009.

798 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

799 Interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

800 Interview with Dr. Grace Omoni, Senior Lecturer in Obstetrics and Midwifery, Dr. Blasio Omuga, Lecturer in Obstetrics and Midwifery and OB/GYN, Mrs. Margaret Mwiva, Senior Lecturer in Medical/Surgical Nursing, Mrs. Theresa Odero, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.

801 *See* MOH at 25.

802 Interview with Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009.

803 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.

804 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.

805 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009. *See also* interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

806 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

807 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

808 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

809 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009.

810 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009 and Nov. 2, 2009.

811 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.

812 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009.

813 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

814 Interview with Dr. Zahida Qureshi, Professor of OB/GYN, University of Nairobi/Kenyatta National Hospital, Nairobi, Aug. 10, 2009.

815 Interview with Mercy Mathai, Nurse, Private Practice, Nairobi, June 30, 2009.

816 *Id*.

817 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009; interview with Nurse, Private Clinic in Manyatta, Kisumu, July 9, 2009 (name withheld).

818 Interview with Nurse, Private Clinic, Mbita, July 6, 2009 (name withheld).

819 *E.g.,* interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld); interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

820 Interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

821 Interview with Dr. Mitei, Obstetrician-Gynecologist Consultant, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Sarah Abuyeka, Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.

822 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009; interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009; interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

823 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

824 Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.

825 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.

826 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

827 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

828 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.

829 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009.

830 *Id*.

831 *Id*.

832 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.

833 *Id.*
834 *Id.*
835 *Id.*
836 *Id.*
837 Ipas, Processing Ipas MVA Plus® Aspirators and Adapters (2007) *available at* http://www.ipas.org/Publications/asset_upload_file72_3241.pdf (last visited Feb 10, 2010).
838 2004 KSPAS at Table 6.6, 131.
839 *Id. at* Table 6.6, 131 (Nov. 2005).
840 *Id.* at Appendix B, Table A-6.32, 283 (Nov. 2005).
841 *Id.*
842 Interview with Dr. Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.
843 Interview with Nurse, Private Clinic, Mbita, July 6, 2009 (name withheld).
844 Interview with Mercy Mathai, Nurse, Private Practice, Nairobi, June 30, 2009.
845 Dr. Margaret Meme, Gender and Reproductive Rights Program, and Dr. Annie Gituto, Maternal Newborn Health Program, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 6, 2009.
846 World Health Organization, Unsafe abortion: new estimates, Progress, No. 76 (2008) 7 *available at* http://www.who.int/hrp/Progress76.pdf.
847 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
848 *Id.*
849 *Id.*
850 *Id.*
851 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
852 *Id.*
853 *Id.*
854 Interview with Clinical Officer at public hospital, Kisumu, July 27, 2009
855 Christine Ong'ete, Reproductive Health Coordinator for Suba District, Mbita, July 6, 2009. She admitted that "[t]here is a problem with documentation" because providers offer PAC services "without reporting." She explained, "it's not documented because it's done privately."
856 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
857 Interview with Clinical Officer, Kisumu, July 27, 2009 (name withheld).
858 Interview with Felix Oiki, KEPI Coordinator, Suba District Health Management Team, Mbita, July 6, 2009.
859 Interview with Sylverns Ater Kagose, Nurse Manager, Suba District Hospital, Sindo, July 8, 2009.
860 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.
861 *Id.*
862 *Id.*
863 Interview with Dr. Margaret Meme, Gender and Reproductive Rights Program, and Dr. Annie Gituto, Maternal Newborn Health Program, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 6, 2009.
864 *Id.*
865 *Id.*
866 *Id.*
867 Interview with Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug., 10, 2009.
868 Interview with Dr. Margaret Meme, Gender and Reproductive Rights Program, and Dr. Annie Gituto, Maternal Newborn Health Program, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 6, 2009.
869 International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976)[hereinafter Economic, Social and Cultural Rights Covenant].
870 Committee on Economic Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, para. 43(f), U.N. Doc E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR General Comment No. 14].
871 *Id. at* para. 12(b).
872 Interview with Oscar Oyata, Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
873 From Statistics Office at Kisumu District Hospital – referred there by Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
874 *Id.*
875 Interview with Dr. Njoroge Waithaka, Head of OB/GYN Department, Kenyatta National Hospital, Nairobi, Aug. 11, 2009.
876 Interview with Monica Oguttu, Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.
877 David A. Grimes et al., *Unsafe abortion: the preventable pandemic*, 368 The Lancet at 1915 (Nov. 2006), citing Billings DL and Benson J *Postabortion care in Latin America: policy and service recommendations from a decade of operations research*, 20 Health Policy Plan (2005) 1443-53; A Langer et al., *Improving postabortion care with limited resources in a public hospital in Oaxaca, Mexico*, printed in: D Huntington et al., Post-abortion care: lessons from operations research (1999); J Solo et al., *Creating linkages between incomplete abortion treatment and family planning services in Kenya*, 30 Studies in Family Planning (1999) at 17-27; DL Billings et al., *Comparing three models of postabortion care in public hospitals in Mexico city*, 29 International Family Planning Perspectives (2003) at 112-120; and BR Johnson et al., *Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception*, 33 Studies in Family Planning (2002) at 195-202.
878 Dr. Bartilol Kigen, former Head, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 10, 2009.
879 Dr. Margaret Meme, Gender and Reproductive Rights Program, and Dr. Annie Gituto, Maternal Newborn Health Program, Division of Reproductive Health, Ministry of Health, Nairobi, Aug. 6, 2009.
880 Medical Practitioners and Dentists Code of Conduct at Appendix II: The Internal Code of Medical Ethics – 1949 at 32.
881 Republic of Kenya, Ministry of Health, issued by Clinical Officers' Council, The Code of Professional Conduct for Clinical Officers, Appendix I: Functions of the Clinical Officers' Council at 21 (no date available).
882 Medical Practitioners and Dentists Code of Conduct, Chapter IV, I(a)(1) at 16.
883 Interview with Dr. Boaz Nyunya, Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.
884 *Id.*
885 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld); *see also* interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
886 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
887 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
888 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
889 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
890 Interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
891 *Id.*
892 *Id.*
893 *Id.*
894 *Id.*
895 *Id.*
896 *Id.*
897 Interview with Nurse, private clinic, Mbita, July 6, 2009 (name withheld).
898 Interview with Dr. Stephen Ochiel, Obstetrician-Gynecologist, University of Nairobi, Nairobi, June 19, 2009.
899 *Id.*
900 E-mail from Dr. Stephen Ochiel, Obstetrician-Gynecologist, University of Nairobi, to Center for Reproductive Rights, Jan. 26, 2010 (on file at the Center for Reproductive Rights).
901 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
902 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.
903 *Id.*
904 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.
905 Interview with Faith Mbehero, Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009.
906 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
907 Interview with Nurse, Nairobi, June 30, 2009 (name withheld).

908 *Id.*
909 *Id.*
910 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009 (name withheld).
911 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
912 Interview with Mercy Mathai, Nurse, Reproductive Health Services, Nairobi, June 30, 2009.
913 Interview with Clinical Officer, Private Clinic, Dandora Phase I, July 3, 2009 (name withheld).
914 *Id.*
915 E-mail with attachment from Dr. John Nyamu, Obstetrician-Gynecologist, Reproductive Health Services, to Reproductive Health and Rights Alliance, Nov. 4, 2009 (on file with the Center for Reproductive Rights).
916 *Id.*
917 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Nov. 3, 2009.
918 *Id.*
919 Interview with Dr. Stephen Ochiel, Obstetrician-Gynecologist, University of Nairobi, Nairobi, June 19, 2009.
920 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 22 (2004).
921 *Id.* at 4.
922 *Id.* at 25.
923 *Id.* at 1.
924 JKG Mati, *One More Plea on Abortion: A Commentary on Draft Constitution* as cited in Kenya Medical Association, *Maternal Deaths and Unsafe Abortion in Kenya* (Report of a workshop held at Panafric Hotel, Nairobi, Nov. 4th – 6th, 2004) at 60, *available at* http://www.kma.co.ke/downloads/maternal/maternal-deaths.pdf.
925 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 21 (2004).
926 2004 KSPAS, *Overview of the health system in Kenya* at 24.
927 Interview with Dr. Joseph Karanja, Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009.
928 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 21 (2004).
929 International Planned Parenthood Federation, Death and Denial: Unsafe Abortion and Poverty at 10 (2006), *available at* http://www.ippf.org/NR/rdonlyres/8D4783F5-D516-47D3-8B34-61F6D510202A/0/Death_Denial_unsafe_abortion_poverty.pdf (last visited Feb. 4, 2010).
930 Wamwana, *Kakamega study* at 665.
931 *The magnitude of abortion complications in Kenya* at 1233.
932 *The preventable pandemic* at 1911.
933 *The magnitude of abortion complications in Kenya* at 1233.
934 *Id.*
935 Ipas, A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya 25 (2004).
936 *The magnitude of abortion complications in Kenya* at 1233.
937 Interview with Joachim Osur, reproductive health expert, Nairobi, Nov. 2, 2009.
938 *Id.*
939 *The preventable pandemic* at 1914, citing Heidi Johnston, 2004; Ipas, Chapel Hill, NC, USA.
940 *Id.* at 1913 (Nov. 2006).
941 African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev.5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter African Charter]. The African Charter obliges state parties to "ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." Article 18(3).
942 African Charter on the Rights and Welfare of the Child, *adopted* July 1990, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) [hereinafter African Children's Charter].
943 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique [hereinafter Maputo Protocol].
944 African Commission on Human and Peoples' Rights, Status of Ratification/Accession to OAU/AU Human Rights Treaties, *available at* http://www.achpr.org/english/_info/index_ratifications_en.html (last visited Feb. 12, 2010).
945 Vienna Convention on the Law of Treaties, art. 18(a), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980).
946 Maputo Protocol at art. 26.
947 International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter Civil and Political Rights Covenant].
948 Economic, Social and Cultural Rights Covenant.
949 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].
950 Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990).
951 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987).
952 Vienna Convention on the Law of Treaties, art. 2.1(b), May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980). *See also*, *Vienna Declaration and Programme of Action*, World Conference on Human Rights, para. 1, Vienna, Austria, July 14-25, 1993, U.N. Doc. A/CONF 157/23 (1993) (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law.").
953 *Programme of Action of the International Conference on Population and Development,* Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995); *African Platform for Action of the Fifth African Regional Conference on Women*, Dakar, Senegal, 16-23 Nov., 1994 (1995); Beijing *Platform for Action, Fourth World Conference on Women*, Sept. 15, 1995, U.N. Doc. A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995). The consensus documents that emerged from these conferences are not legally binding on states. However, by setting forth a detailed, global mandate, these documents contribute to advancing and interpreting the human rights standards contained in human rights treaties.
954 United Nations, The Millennium Development Goals Report 8-9, 12-15 (2006), *available at* http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf.
955 Universal Declaration of Human Rights, art. 1, *adopted* Dec. 10, 1948, G.A. Res. 217A(III), at 71, U.N. Doc. A/810 (1948) [hereinafter Universal Declaration]; Civil and Political Rights Covenant, art.6; African Charter at art. 4; Convention on the Rights of the Child, art. 6, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. HAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448; The Constitution of Kenya at cap. 5 §70(a).
956 Human Rights Committee, *General Comment No. 6, The right to life,* para. 5, U.N. Doc. 30/04/82 (1982).
957 Human Rights Committee, *General Comment No. 28, Equality of rights between men and women (article 3)*, para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).
958 *See* Human Rights Committee, Concluding Observations, El Salvador, para. 14, U.N. Doc. CCPR/CO/78/SLV (2004); Guatemala, para. 19, U.N. Doc. CCPR/CO/72/GTM (2001); Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005); Mauritius, para. 9, U.N. Doc. CCPR/CO/83/MUS (2005).
959 *See* Human Rights Committee, Concluding Observations, Gambia, para. 17, U.N. Doc. CCPR/CO/75/GMB (2004); Kenya, para. 14, U.N. Doc, CCPR/CO/83/KEN (2005).
960 Human Rights Committee, Concluding Observations, Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005).

961 *See* Committee on the Rights of the Child, Concluding Observations, Chad, para. 30, U.N. Doc. CRC/C/15/Add.107 (1999).

962 *See* Committee on the Rights of the Child, Concluding Observations, Honduras, para. 61, U.N. Doc. CRC/C/HND/CO/3 (2007); Mozambique, para. 46, U.N. Doc. CRC/C/15/Add.172 (2002); Nicaragua, para. 19, U.N. Doc. CRC/C/15/Add.36 (1995).

963 *See* Committee on the Rights of the Child, Concluding Observations, Benin, para. 55, U.N. Doc. CRC/C/BEN/CO/2 (2006); Colombia, para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); Peru, paras. 52-53, U.N. Doc. CRC/C/PER/CO/3 (2006); Venezuela, paras. 60-61, U.N. Doc. CRC/C/VEN/CO/2 (2007).

964 Committee on the Rights of the Child, Concluding Observations, Kenya, para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).

965 *See* CEDAW Committee, Concluding Observations, Belize, para. 56, U.N. Doc. A/54/38 (1999); Colombia, para. 393, U.N. Doc. A/54/38 (1999); Dominican Republic, para. 337, U.N. Doc. A/53/38 (1998).

966 *See* CEDAW Committee, Concluding Observations, Brazil, paras. 29-30, U.N. Doc. CEDAW/C/BRA/6 (2007); Chile, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); Honduras, para. 25, U.N. Doc. CEDAW/C/HON/CO/6 (2007); Mauritius, para. 31, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); Nicaragua, para. 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); Pakistan, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007); Peru, para. 482, U.N. Doc. A/57/38 (2002); Philippines, para. 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).

967 CEDAW Committee, Concluding Observations, Kenya, para. 37, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).

968 CEDAW Committee, Concluding Observations, Kenya, para. 38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).

969 *See, e.g.,* CEDAWCommittee, Concluding Observations, Belize, para. 56, U.N. Doc. 1/54/38 (1999); Human Rights Committee, Concluding Observations, Madagascar, para. 14, U.N. Doc. CCPR/C/MDG/CO/3 (2007).

970 *See, e.g.,* Committee on Economic, Social, and Cultural Rights, Concluding Observations, Nepal, para. 55, U.N. Doc. E/C.12/1/Add.66 (2001); Human Rights Committee, Concluding Observations, Gambia, para. 17, U.N. Doc. CCPR/CO/75/GMB (2004); Committee on the Rights of the Child, Concluding Observations, Guatemala, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001); CEDAW Committee, Concluding Observations, Mauritius, U.N. Doc. CEDAW/C/MAR/CO/5 (2006).

971 Human Rights Committee, Concluding Observations, Zambia, para. 18, U.N. Doc. CCPR/C/ZMB/CO/3 (2007).

972 Human Rights Committee, Concluding Observations, Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005).

973 Universal Declaration, Art. 1, (emphasis added by the Center for Reproductive Rights).

974 UN GAOR Annex, 12th Session, Agenda Item 33, at 96, UN Doc. A/C.3/L.654; UN GAOR, 12th Session, Agenda Item 33, at 113 UN Doc. A/3764, 1957. The Commission ultimately voted to adopt Article 6, which has no reference to conception, by a vote of 55 to nil, with 17 abstentions. UN GAOR, 12th Session, Agenda Item 33, at 119 (q), UN Doc. A/3764, 1957.

975 Kéba Mbaye, Draft African Charter on Human and Peoples' Rights, Art. 17: Right to Life, O.A.U. Doc. CAB/LEG/67/1 (1979).

976 CEDAW at preamble.

977 Maputo Protocol at Art. 14(2)(c).

978 *See, e.g.*, CEDAW at art. 12; ICESCR at art. 12; *Programme of Action of the International Conference on Population and Development* at principle 8, U.N. Doc A/CONF.171/13/Rev.1 (1995); Beijing Declaration and Platform for Action at para. 91 (1995); CRC at art. 166; African Charter at art. 16; Maputo Protocol at art. 14.

979 CESCR General Comment No. 14 at paras. 8 and 11.

980 ICESCR at art. 2.

981 CESCR, *General Comment No. 3: The nature of States parties obligations,* para. 9, U.N. Doc. E/1991/23 (Dec. 14, 1990).

982 CESCR General Comment No. 14 at para. 52.

983 Maputo Protocol at Art. 14(2)(c).

984 *See, e.g.,* Committee on Economic, Social, and Cultural Rights, Concluding Observations, Nepal, paras. 32-33, 55, U.N. Doc. E/C.12/1/Add.66 (2001); CEDAW Committee, Concluding Observations, Tuvalu, para. 43, U.N. Doc. CEDAW/C/TUV/CO/2 (2009); Committee on Economic, Social, and Cultural Rights, Concluding Observations, Bolivia, para. 43, U.N. Doc. 3/C.12/1/Add.60 (2001); Committee on Economic, Social, and Cultural Rights, Concluding Observations, Costa Rica, paras. 25 and 46,U.N. Doc. E/C/12/CRI/CO/4 (2008).

985 Committee on Economic, Social, and Cultural Rights, Concluding Observations, Brazil, para. 51, U.N. Doc. E/C.12/1/Add.87 (2003).

986 Committee on the Rights of the Child, Concluding Observations, Kenya, para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007); Committee on Economic, Social, and Cultural Rights, Concluding Observations, Kenya, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

987 Committee Against Torture, Concluding Observations, Chile, para. 7(m) U.N. Doc. CAT/C/CR/32/5 (2004).

988 CEDAW Committee, Concluding Observations, Tuvalu, para. 44, U.N. Doc. CEDAW/C/TUV/CO/2 (2009).

989 Children's Rights Convention at art. 24(2); African Children's Charter, art. 14(2)(b).

990 African Charter, art. 16(1).

991 Committee on the Rights of the Child, Concluding Observations, Kenya, paras. 49-50, U.N. Doc. CRC/C/KEN/CO/2 (2007); Committee on Economic, Social, and Cultural Rights, Concluding Observations, Kenya, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008); Human Rights Committee, Concluding Observations, Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005).

992 *See* CESCR General Comment No. 14 at paras. 12 (stating that accessibility consists of non-discrimination, physical accessibility, affordability, and access to information) and 35.

993 *Id*. at para. 12(a).

994 *Id*. at para. 43(d).

995 World Health Organization, WHO Model List of Essential Medicines, 23, (16th ed. Mar. 2009) *available at* http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf.

996 *Id*. *at* 27.

997 World Health Organization, WHO Model List of Essential Medicines, Explanatory Notes, (16th ed. Mar. 2009) *available at* http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf.

998 World Health Organization et al., Interagency List of Essential Medical Devices for Reproductive Health, 16, (2008) *available at* http://www.who.int/medicines/publications/MRfinalmedicaldevskhoct08.pdf.

999 2004 KSPAS Appendix B, Table A-6.36, 287.

1000 CESCR General Comment No. 14 at para. 12(b).

1001 *Id*. at para. 43(a).

1002 *Id*. at para. 12(b).

1003 *Id*.

1004 *Id*.

1005 *Id*.

1006 *Id*. at para. 12(c).

1007 CESCR General Comment No. 14 at para. 12(d).

1008 *Id*. at para. 12(d).

1009 *Id*. at para. 36.

1010 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, para. 30, U.N. Doc. E/CN.4/2004/49 (Feb. 16, 2004).

1011 CEDAW Committee, Concluding Observations, Kenya, paras. 37-38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).

1012 Ipas, Misoprostol and Medical Abortion in Africa 1 (2009) *available at* www.ipas.org/Publications/asset_upload_file683_4512.pdf.

1013 *Id*.

1014 Joachim Osur et al. with Ipas, Misoprostol for Management of Incomplete and Missed Abortions: A Clinical Protocol (2009) 5.

1015 Suellen Miller et al., *Misoprostol and Declining Abortion-Related Morbidity in Santo Domingo, Dominican Republic: A Temporal Association*, 112(9) BJOG: An International Journal of Obstetrics and Gynaecology 1291, 1291-2 (Sept. 2005).

1016 Ipas, Misoprostol and Medical Abortion in Africa 1 (2009) *available at* www.ipas.org/Publications/asset_upload_file683_4512.pdf (last visited Feb. 4, 2010).

1017 Civil and Political Rights Covenant, art. 9(1); African Charter, art. 6.

1018 Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika

Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44: Addendum: Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women, para. 48, U.N. Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999), *available at* http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/4cad275a8b5509ed8025673800503f9d?Opendocument.

[1019] Universal Declaration at arts. 13, 23, and 27; Economic, Social and Cultural Rights Covenant at arts. 6 and 15; Civil and Political Rights Covenant, art. 12(Article 12 of the Civil and Political Rights Covenant guarantees protection "not only from public but also from private interference."); Human Rights Committee, *General Comment No. 27: Freedom of movement*, U.N. Doc CCPR/C/21/Rev. 1/Add. 9 (Nov. 2 1999). International Covenant on Civil and Political Rights, General Comment No. 27 at para. 6.

[1020] Mark W. Yanis, *An Introduction to International Law*, 259-60 (2003).

[1021] Universal Declaration at art. 5; Civil and Political Rights Covenant at art. 7; Convention against Torture at arts. 2, 16; African Charter at art. 5; African Children's Charter at art.16 (1). In addition, the Maputo Protocol prohibits "[a]ll forms of exploitation, cruel, inhuman or degrading punishment and treatment," and requires state parties to take measures to protect women from all forms of sexual violence. Maputo Protocol at arts. 3, 4.

[1022] African Charter at art. 5.

[1023] Human Rights Committee, *General Comment 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment* at para. 5, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994).

[1024] *Id.*

[1025] *Id.*

[1026] Human Rights Committee, *General Comment 28: Equality of rights between men and women* at para. 11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000).

[1027] Human Rights Committee, Concluding Observations, Morocco, para. 29, U.N. Doc. CCPR/CO/82/MAR (2004).

[1028] *K.L. v. Peru,* communication no. 1153/2003, §6.3, United Nations Human Rights Committee (2005).

[1029] Human Rights Committee, *General Comment 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment* at para. 2, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994).

[1030] *See* Committee Against Torture, Concluding Observations, Nicaragua, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); Peru, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006).

[1031] Committee Against Torture, Concluding Observations, Nicaragua, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).

[1032] Committee Against Torture, Concluding Observations, Chile, para. 7(m) CAT/CR/32/5 (2004).

[1033] The CEDAW Committee defines gender-based violence as "acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty," stating that such acts of gender-based violence impairs or nullifies women's fundamental rights, including "[t]he right not to be subject to torture or to cruel, inhuman or degrading treatment." CEDAW *General Recommendation No. 19: Violence against women* at paras. 6, 7, U.N. Doc. A/47/38 (1992).

[1034] Civil and Political Rights Covenant at art. 2, 3; Economic, Social and Cultural Rights Covenant at art. 2, 3; African Charter at arts. 2, 3, 18(3); Committee on Economic Social and Cultural Rights, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights*, para 1, U.N. Doc. E/C.12/2005/4 (2004).

[1035] *See, e.g.*, Universal Declaration at art. 2; Civil and Political Rights Covenant at art. 2(1); International Convenant on Economic, Social and Cultural Rights at art. 2(2); African Charter at art. 2.

[1036] African Charter at arts. 3(1), 18(3).

[1037] *See* Maputo Protocol at art. 2.

[1038] Human Rights Committee, *General Comment No. 28: Equality of rights between men and women (article 3)*,para. 11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000).

[1039] CEDAW Committee, *General Rec. No. 24: Women and health*, para. 14, U.N. Doc. A/54/38 at 5 (1999).

[1040] *Id.* at para. 31(c).

[1041] Human Rights Committee, Concluding Observation, Argentina, para. 14, U.N. Doc. CCPR/CO.70/ARG (2000).

[1042] Committee on Economic, Social and Cultural Rights, Concluding Observations, Kenya, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

[1043] Committee on Economic, Social, and Cultural Rights, *General Comment No. 1: The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3)*, para. 29, U.N. Doc. E/C.12/2005/4 (2005).

[1044] CEDAW Committee, Concluding Observations, para. 37, CEDAW/C/KEN/CO/6 (2007).

[1045] CESCR General Comment No. 14 at paras. 18, 19, 22; Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development*, paras. 6, 41, U.N. Doc. CRC/GC/2003/4 (2003).

[1046] Universal Declaration at art. 1; Civil and Political Rights Covenant at Preamble; African Charter at art. 5; African Children's Charter at arts. 11(5).

[1047] Civil and Political Rights Covenant at Preamble.

[1048] *Id.*

[1049] African Charter, at art. 5.

[1050] Maputo Protocol at arts. 3(4).

[1051] African Children's Charter at arts. 11(5), 17(1), 20(1)(c)).

[1052] Beijing *Platform for Action, Fourth World Conference on Women*, Sept. 15, 1995, para. 106k, U.N. Doc. A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995), *available at* http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf.

[1053] African Charter at arts. 9(1), 17(1).

[1054] Maputo Protocol at arts. 14.1(g), 14.2(a).

[1055] CEDAW Committee, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 14(b), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981).

[1056] CEDAW Committee, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 16.1(e), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981).Further elaborating on these rights, the CEDAW Committee has stated: "In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services." CEDAW General Recommendation No. 21 at para. 22.

[1057] CEDAW General Recommendation No. 21 at para. 22.

[1058] CEDAW Committee, Concluding Observations, para. 37, CEDAW/C/KEN/CO/6 (2007).

[1059] *Id.* at para. 38.

[1060] Convention on the Rights of the Child, *adopted* Nov. 20, 1989, art. 24.2(f), G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990). In numerous concluding observations, the Committee on the Rights of the Child has recommended that State Parties strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other STDs. *See, e.g.,* Committee on the Rights of the Child, Concluding Observations, Egypt, para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); Georgia, para. 51, U.N. Doc. CRC/C/15/Add.222 (2003); Latvia, para. 45(a) and (c), U.N. Doc CRC/C/LVA/CO/2 (2006). Further the Committee has suggested that girls should have access to information on the harm that early pregnancy can cause, and that those who become pregnant should have access to services sensitive to their particular needs. *See* Committee on the Rights of the Child, *No. 4: Adolescent health and development*, para. 31, U.N. Doc. CRC/GC/2003/4 (2003).

[1061] Committee on the Rights of the Child, Concluding Observations, Kenya, para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).

[1062] *Id.* at para. 50(a).

[1063] CESCR General Comment No. 14 at para. 11.

[1064] *Id.* at 12(b).

[1065] Committee on Economic, Social and Cultural Rights, Concluding Observations, Kenya, para. 33, U.N. Doc. E/C.12/KEN/CO/1 (2008).

[1066] Civil and Political Rights Covenant at art. 17.

[1067] Universal Declaration at art. 12.

[1068] Civil and Political Rights Covenant at art. 17.

[1069] Human Rights Committee, *General Comment No. 16: The right to respect of*

privacy, family, home and correspondence, and protection of honour and reputation (Art. 17), paras. 1and 9 (Apr. 8, 1988).

[1070] *K.L. v. Peru,* communication no. 1153/2003, §6.4, United Nations Human Rights Committee (2005).

[1071] *Id.*

[1072] CESCR General Comment No. 14 at para. 3.

[1073] *Id.* at para. 8.

[1074] CEDAW Committee, *General Recommendation No. 24: Women and Health*, para. 14, U.N. Doc. A/54/38 at 5 (1999), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

[1075] *Id.* at,para. 31(e).

[1076] Human Rights Committee, *General Comment No. 19 (Art. 23)*, (Thirty-ninth session, 1990), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 5, U.N. Doc. HRI/GEN/1/Rev.1 at 28 (1994).

[1077] *See, e.g.,* Universal Declaration at art. 8; International Covenant on Civil and Political Rights, art. 2.3(a), G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); Maputo Protocol at art. 25. In explaining the right to an effective remedy, the Human Rights Commission states that not only does the International Covenant on Civil and Political Rights establish that States must protect individuals from rights violations, but States must also take positive steps towards ensuring that, when violations do occur, "accessible and effective remedies" are available in order to "vindicate those rights." Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation on States Parties to the Covenant*, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004).

[1078] Maputo Protocol at art. 25(a).

[1079] Human Rights Committee, *General Comment No. 31: Nature of the General Legal Obligation on States Parties to the Covenant*, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004).

[1080] CEDAW Committee, *General Recommendation No. 24: Women and Health*, para. 13, U.N. Doc. A/54/38 at 5 (1999), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 271 (2003).

[1081] CESCR General Comment No. 14 at para. 59 ("Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.")

[1082] *K.L. v. Peru,* communication no. 1153/2003, §6.6, United Nations Human Rights Committee (2005).

[1083] *Id.* at §3.1.

[1084] *Id.* at §2.8.

[1085] Universal Declaration at art. 11.1.

[1086] Civil and Political Rights Covenant, arts. 14.3(d) and 14.3(g).

[1087] African Charter at, art. 7.1(c).

[1088] African Children's Charter at arts. 17.2(c) and 17.2(c)(iii).

[1089] Committee against Torture, Concluding Observations, Kenya, para. 10, U.N. Doc. CAT/C/KEN/CO/1 (2009).

[1090] *Id.*

[1091] Committee on the Rights of the Child, Concluding Observations, Kenya, para. 67, U.N. Doc. CRC/C/KEN/CO/2 (2007).

[1092] *Id.* at para. 68(i).

Kenya's abortion law is among the most restrictive in the world, criminalizing abortion except to save the life of the pregnant woman.

This law is accompanied by a confusing patchwork of policies and regulations which do little to facilitate access to safe abortion services. The stigma and criminalization that surround abortion further affect access to, and the quality of, post-abortion care services, which are often unavailable, too expensive, or characterized by abusive treatment. *In Harm's Way: The Impact of Kenya's Restrictive Abortion Law*, produced by the Center for Reproductive Rights, documents the human rights abuses stemming from the criminalization of abortion and throws into sharp relief the need to comprehensively address the toll of unsafe abortion in Kenya.

"Lack of access to safe abortion in Kenya has created a grave public health crisis that can no longer be ignored by the government or the public. Thousands of Kenyan women are dying or hospitalized annually due to unsafe abortion. This report documents the violations fueling women's recourse to unsafe abortion, the barriers to safe abortion or post-abortion care, and the multiple harms experienced by women who encounter these barriers. This restrictive legal regime also creates challenges for healthcare providers who offer abortion-related services and strains Kenya's healthcare system. The report makes clear that the cost of denial is too high—women's lives and health and their families' well-being are at stake, as are our healthcare system's scarce resources.

The findings of this report are a call to action. If we are serious about reducing our high maternal mortality rates and meeting the Millennium Development Goals and Vision 2030, we must address the devastating consequences of Kenya's restrictive abortion law." **The Reproductive Health and Rights Alliance, Kenya**

The Reproductive Health and Rights Alliance is a coalition of medical, legal, women's rights and human rights professionals and advocates, and sexual and reproductive health and rights organizations, dedicated to advocacy for improved reproductive health laws, policies, and practices in Kenya.

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