

December 14, 2006

The Committee on the Rights of the Child

Re: Supplementary information on Kenya scheduled for review by the Committee on the Rights of the Child during its 44th Session

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by Kenya, which is scheduled to be reviewed by the Committee on the Rights of the Child (the Committee) during its 44th session. The Federation of Women Lawyers – Kenya (FIDA Kenya), a national women’s rights non-governmental organization based in Kenya and the Center for Reproductive Rights, a US-based non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Rights of the Child (Children’s Rights Convention). This letter highlights several areas of concern related to the status of the reproductive health and rights of girls and adolescents in Kenya, with a focus on access to reproductive health services and freedom from gender-based violence.

Because reproductive rights are fundamental to adolescents’ health and equality, states parties’ commitment to ensuring them should receive serious attention. Furthermore, adolescent reproductive health and rights receive broad protection under the Children’s Rights Convention. Article 24 of the Children’s Rights Convention recognizes girls’ and adolescents’ right “to the enjoyment of the highest standard of health and to facilities for the treatment of illness and rehabilitation of health.” It also requires states parties to take appropriate measures “to develop family planning and education services.” Yet, despite these protections, the reproductive rights of girls and adolescents in Kenya continue to be neglected and, at times, blatantly violated.

Fifty-five percent of Kenya’s total population is 19 years of age or younger and half of that group are adolescents between the ages of 10-19.¹ Despite this large number of young people reaching reproductive maturity, preconceived notions about adolescent sexuality have led law and policy makers to largely ignore their specific health needs. This approach has made adolescents vulnerable to a host of health problems, sexual violence, and abuse. Laws, policies, and programs that cater specifically to adolescents’ reproductive health needs are necessary to ensure and advance the fundamental rights to life, health, self-determination and non-discrimination of this vulnerable group. Effective implementation of these tools is essential to ensure any improvement in adolescents’ health and social status which, at present, is a matter of very serious concern.

We wish to bring to the Committee’s attention the following issues of concern, which directly affect the reproductive health and rights of girls and adolescents in Kenya:

I. The Right to Reproductive Health Services (Article 24 of the Children’s Rights Convention)

Article 6 of the Children’s Rights Convention stipulates that each child has an inherent right to life. Moreover, the State must do everything in its power to guarantee the survival and development of the child. Article 24 expands these rights by recognizing children’s right to enjoy the highest attainable standard of health. These clauses obligate the government to ensure adolescents’ access to reproductive health services. In the absence of these services, adolescent girls may experience unwanted pregnancies, possibly resulting in death or illness due to the girls’ physical immaturity and the lack of adequate maternal health care, or they may seek out unsafe illegal abortions which could also result in complications or death.

The Committee has regularly expressed concern in its Concluding Observations where adolescents have limited access to reproductive health services and has asked states parties to increase women’s and adolescents’ access to such services.² It has frequently drawn attention to high rates of maternal mortality affecting adolescents,³ highlighting the need to address unsafe or illegal abortion⁴ and teenagers’ lack of access to reproductive health services.⁵

The government of Kenya recently increased funding for the health sector, allocating 9.4% of its gross domestic product, or Sh43 billion (approximately USD \$582 million), to the Ministry of Health budget. This is an increase of Sh13 billion (approximately USD \$176 million) from the previous year.⁶ However, this allocation still falls short of the 2001 commitment made by African heads of state and the government of the Organisation of African Unity (now the African Union) to allocate 15% of annual national budgets to bettering health services.⁷ While Kenya has identified reproductive health as a priority within the Ministry of Health and one-quarter of its budget will be dedicated to reproductive health,⁸ it remains to be seen how much of this money will address adolescent reproductive health needs.

A. Reproductive Health Education

The Committee, in evaluating state party compliance with the Children’s Rights Convention, has recognized states’ duty to ensure access to sexual and reproductive health education. In numerous Concluding Observations, the Committee has recommended that states parties strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other STIs.⁹ Further, the Committee has suggested in its General Comment that adolescent 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.¹⁰

In responding to Kenya’s initial report in 2001, the Committee recommended that Kenya “strengthen adolescent health policies, including reproductive health education. . . .”¹¹ Kenya acknowledged this and developed its Adolescent Reproductive Health and Development Policy. Its plan of action directly states that “[i]nformation and education on sexual and reproductive health is important for adolescents.”¹² Furthermore, according to the plan of action, “[t]hey need accurate, appropriate information to help them understand their sexuality and the reproductive process as they grow, as this would enable them to make sound choices, enjoy healthy and positive lifestyles, and avoid undesired consequences like unwanted pregnancies and sexually transmitted infections.”¹³

It is evident that the government formally recognizes the underlying social factors that predispose adolescents to serious reproductive health problems. However, the early age of sexual debut, high rates of maternal death, and ignorance about safe sex and sexuality raises serious questions about the effective implementation of this and similarly designed programs.

The 2003 KDHS found that over half of all births to adolescents under age 20 take place at home,¹⁴ while only 47% were supervised by a doctor, nurse or midwife.¹⁵ The maternal mortality ratio for adolescents 15-19 is 204 deaths per 100,000 live births.¹⁶ Children born to adolescent mothers are normally predisposed to higher risks of illness and death and adolescent mothers are more likely to experience complications during and after pregnancy like prolonged labor and fistula. Adolescents are less likely to be prepared to deal with these complications, which can lead to maternal death.¹⁷ This early entry into reproduction often denies young women the opportunity to pursue basic education and is detrimental to their prospects for good careers, which often lowers their status in society.¹⁸

Statistics also show that of the adolescents surveyed for the KDHS, 14.5% of girls had their first sexual encounter by the time they reached age 15 and 30.9% of boys, were sexually active before reaching that age.¹⁹ The KDHS found a strong relationship between age of sexual debut and educational level attained, particularly for women. While 25% of women age 15-24 with no education had sex by age 15, only 4% with at least some secondary education did so.²⁰

B. Access to Family Planning and Dual Protection Methods

Access to dual protection methods, which can simultaneously prevent both unwanted pregnancies and sexually transmissible infections (STIs), is central to protecting adolescents' right to life and health. The Committee has regularly expressed concern in its Concluding Observations regarding limited access to family planning services and low levels of contraceptive use among adolescents, and has recommended that states parties work toward making family planning services more widely available.²¹

It is critical that the government of Kenya place greater emphasis on the provision of accurate information to adolescents regarding contraceptive use in a way that is both comprehensive and accessible to members of this age group. Efforts to disseminate this information must incorporate practical information as to where adolescents can access contraception as well as to where they can access affordable medical services in relation to contraception. Finally it is vital that information and services reach all segments of the adolescent population, including those with minimal or no education and, further, that efforts be made in general so that educational opportunities are more widely accessible. It is also necessary for information and services to reach those belonging to the lowest socio-economic groups, including street children.

Statistics demonstrate that there is an unmet need for contraception among adolescents in Kenya. While only surveying currently married women, the KDHS 2003 found the unmet family planning need among married young women, age 15-19, was 27.8%.²² The survey also showed 20.5% of births to women under 20 are unwanted and another 26% are mistimed.²³ The KDHS also found that only 12% of women and 10% of men age 15-19 used a condom during their first sexual encounter.²⁴ Dwindling donor support for family planning facilities, inadequate government funding for contraceptives, and logistical problems with contraceptive distribution

have created barriers to contraceptive access.²⁵ Lack of access to contraceptives, in turn, contributes to unwanted pregnancies and unsafe abortions.²⁶

Providing services and information that address both family planning and HIV prevention has been further complicated by shifts in funding. With global attention increasingly turning towards HIV/AIDS initiatives, funding usually reserved for family planning programs in Kenya has been funneled instead to HIV/AIDS programs.²⁷ Because of this shift in funding, Marie Stopes International Kenya (MSI Kenya) raised their prices, laid off staff and closed two clinics in 2002.²⁸ The Family Planning Association Kenya (FPAK) closed three clinics in 2001 and 2002 and another three in 2005.²⁹ MSI Kenya and FPAK are among the few places to offer integrated services including family planning, STI management and treatment, post-abortion care, maternal and child health services, pap smear tests, well-baby services and voluntary counseling and testing services for HIV.³⁰ The decrease in availability of integrated services leaves adolescents with fewer places to take care of their reproductive health needs at one time in a setting that can reduce the stigma that may exist around seeking certain services.

C. HIV/AIDS

Accurate information on HIV prevention and treatment is a key component of sexual and reproductive health. In Kenya, however, knowledge of HIV/AIDS risk factors and prevention measures is erratic and comprehension of transmission and prevention routes is especially dismal. More than half of all young women aged 15-19 believe they have no chance of getting HIV and 43.5% of men of the same age share that belief.³¹ Yet young women are particularly vulnerable to HIV infection compared to young men – three percent of women aged 15-19 are HIV positive while less than half of one percent of men aged 15-19 test positive.³² Approximately 70% of Kenyans know that HIV can be transmitted by breastfeeding, but only one-third of women and 38% of men know that the risk of mother-to-child transmission can be reduced by taking certain drugs during pregnancy.³³

Efforts aimed at preventing the spread of HIV usually center on what is known as the ABC approach (abstain until marriage, be faithful within marriage, use condoms) but a recent study in Kenya shows that these terms are misunderstood by the groups they are meant to target.³⁴ The 2004 study showed that while in-school youth were generally aware of HIV, many did not have a clear understanding of what the ABC terms meant.³⁵ Especially worrisome was the finding that two thirds of youth respondents felt that condoms were bad and that they may be “ineffective.”³⁶ This study indicates that ABC programs are not clearly communicating vital information that adolescents need to protect themselves from HIV. (This situation was not improved when Lucy Kibaki, Kenya’s first lady and chair of the Organisation of the 40 African First Ladies against HIV/AIDS, publicly stated that “[t]hose who are still in school have no business having access to condoms.”³⁷) Furthermore, an emphasis on abstinence until marriage is both flawed and dangerous when girls are often forced into non-consensual sexual relations and when marriage itself can actually be a risk factor for contracting HIV.

The high rate of early marriages in Kenya also contributes to the vulnerability of adolescent girls to HIV infection. Approximately 25% of women aged 20-24 in 2003 were married by the time they turned 18 and more than half of those women entered into polygamous marriages.³⁸ A 2001 study among sexually active girls aged 15-19 in Kisumu, Kenya found that HIV infection rates were more than 10 percentage points higher for married than for unmarried girls (married 33%,

unmarried 22%).³⁹ The study found that early marriage increases frequency of sex, decreases condom use, and makes it harder for girls to abstain from sex.⁴⁰ Additionally, husbands of married girls were three times more likely to be HIV-positive than sexual partners of unmarried girls.⁴¹

In spite of the multiple risks early marriage can pose, Kenya's marriage laws do not adequately protect young women. Although the Children Act indirectly defines the minimum age for marriage as 18,⁴² the Marriage Act⁴³ and the Hindu Marriage and Divorce Act⁴⁴ both specify that the minimum age of marriage is 16 for a girl and 18 for a boy. Customary and Islamic laws generally allow adolescents who have reached puberty to marry, regardless of their age.⁴⁵

D. Abortion

Kenya's penal code provisions on abortion, which have not been modified since they were put in place during the colonial period, permit abortion only where there is a threat to the life of the pregnant woman, without regard to her age or the conditions under which she became pregnant.⁴⁶ Unsafe abortion is the cause of 30 to 40% of maternal deaths in Kenya, according to the Kenya Medical Association and Kenya Obstetric and Gynecological Society.⁴⁷ Unsafe abortions among adolescents are also on the rise and according to Kenya's Director of Medical Services, can be attributed to "limited availability of youth-friendly reproductive health services."⁴⁸

These restrictive abortion laws are particularly harsh for low-income young women who cannot afford a costly abortion under safe conditions in Kenya or abroad.⁴⁹ Poorer young women are forced to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications and death. In January 2005, a young orphaned girl bled to death while undergoing a backstreet abortion.⁵⁰ When she realized that being pregnant and having a child would not allow her to continue on her very promising educational path, she sought an illegal, unsafe abortion.⁵¹ The Special Rapporteur on the Right to Education recently noted this lack of options when he wrote that "when poverty combines with marriage and early motherhood, formal education becomes even more distant for teenage girls, who have virtually no choices other than domestic work and raising their children."⁵²

The omission of a rape or incest exception directly contradicts the Human Rights Committee's General Comment 28, which emphasizes the need for access to safe abortion for women who have become pregnant as a result of rape, as well as the provision for access to safe abortion provided for in the Protocol to the African Charter on Women's Rights.⁵³ The Human Rights Committee recently recommended that Kenya "review its abortion laws, with a view to bringing them into conformity with the [International Covenant on Civil and Political Rights]."⁵⁴ In a context where sexual violence is prevalent [as discussed below], young women who have suffered sexual violence run the risk of being further victimized by the lack of access to safe and legal abortion.

II. Violence against Young Girls and Adolescents (Articles 19 and 34 of the Children's Rights Convention)

Article 19 of the CRC provides that states parties must take all appropriate measures to protect the child against all forms of abuse and violence. In addition, Article 34 obliges states parties to take all appropriate measures to protect the child against all forms of exploitation and sexual violence. When young girls are victims of sexual assault, domestic violence, sexual or commercial exploitation, and female genital mutilation, their rights under these clauses are violated. Moreover, these acts infringe upon young women's right to health, as provided in Article 24. Most victims of sexual assault are women.⁵⁵ Thus, the Committee has expressed its concern about the prevalence of all forms of sexual violence against minors.⁵⁶ It considers questions of domestic violence, sexual exploitation, and rape relevant to sexual violence. More specifically, the Committee emphasizes the need to eliminate the practice of female genital mutilation (FGM) and other traditional practices that are harmful to the health of young women because these practices violate their right to bodily integrity and health, as well as their right to be free from violence.⁵⁷

A. Sexual Violence

While sexual violence is widely under-reported, making it difficult to gather fully comprehensive statistics on its prevalence, figures indicate that it is a serious blight on the lives of Kenyan adolescents. According to police sources, 2,908 cases of rape were reported for 2004⁵⁸ and 2,867 for 2005 but hospital statistics indicate that approximately 16,000 cases of rape occur each year.⁵⁹ Unfortunately age-specific data is not collected by either the police or hospitals. The Child Rights Advisory Documentation and Legal Centre (CRADLE), a children's welfare non-governmental organization, says that most victims are under the age of 16 with the most vulnerable being between the ages of 9-16.⁶⁰ In a 2003 survey of 1652 Kenyan women between the ages of 17 and 77, 52% reported being sexually abused in their lifetime while over 30% of the surveyed women reported an experience of forced sexual intercourse in their lifetime.⁶¹ A study in Nairobi indicated that 4% of all HIV infections in adolescents are as a result of rape.⁶²

Some progress in the legislative and law enforcement framework has been made. In May 2006, the Kenyan legislature passed the Sexual Offences Bill 2006. While the act is an improvement over earlier piecemeal and inadequate laws on sexual violence, there are also serious concerns with the new legislation such as the exclusion of marital rape as a punishable offence. Furthermore, the act provides that any person who falsely alleges a sexual offence against another person is guilty of an offence and is liable to punishment equal to that for the offence complained of.⁶³ This provision could discourage reporting of cases of sexual violence for fear of being punished if the case fails—for instance if poor police investigation results in an acquittal.

The National Guidelines for the Medical Management of Rape/Sexual Violence issued by the Division of Reproductive Health in the Ministry of Health outline the importance of providing counseling, emergency contraception, and post-exposure prophylaxis for victims of sexual violence as well as the importance of properly gathering evidence that can be used in prosecution.⁶⁴ However, it appears that the guidelines are not widely disseminated or known.

Sexual violence is also evident in schools throughout Kenya but very little is being done about it. While the action is often criminal in nature, the repercussion felt by the offending teacher is

usually administrative, such as interdiction or suspension.⁶⁵ Inadequate administrative follow-up often results in the offending teacher's reinstatement leading to continued abuse of schoolchildren, while poor investigations and prosecutions lead to a less than 10% conviction rate on cases that are reported to court.⁶⁶ In 2004, a Kiambu primary school justified the return of a teacher who admitted to molesting girls for three years on the grounds that he was a good teacher.⁶⁷

Sexual violence in school can result in negative physical and mental consequences for the abused girl. When a girl is raped there is always the possibility of her becoming pregnant or acquiring an STI, but the consequences go much further than that. Pregnant adolescents can be forced out of school and into early marriages or, as mentioned earlier, unplanned and unwanted pregnancies can lead to illegal, unsafe abortions. Sexual abuse by a teacher or school official can also lead to reluctance on the survivor's part to return to school or to excel in classes out of fear of being noticed by her abuser.⁶⁸ These crimes often go unreported because the victim fears social stigma, negative repercussions at school, or further abuse at the hands of the investigating agency.

B. Female Genital Mutilation

During the 2006 Day of the African Child, the Chairperson of the African Union Commission stressed that FGM was a form of violence against girls and called on member states to "make a solemn commitment to eliminate the practice and help the millions of children who continue to be victims of such devastating practices."⁶⁹ FGM has been linked to obstetric complications and increased risk of death, both at the time of delivery and post-partum.⁷⁰ FGM can also make labor and delivery difficult for women leading to prolonged obstructed labor which is one of the leading causes of obstetric fistula, where a hole develops either between the rectum and vagina or between the bladder and vagina.⁷¹ The resulting leaking of faeces and/or urine can devastate the lives of women who are heavily stigmatized and often shunned by their husbands, families, and communities.⁷²

According to the 2003 KDHS, 20.3% of the 1,856 female adolescents aged 15-19 participating in the survey had undergone FGM.⁷³ Rural women (at 36%) were more likely to be circumcised than urban women (21%).⁷⁴ The Minister of State for Home Affairs estimates that 38% of women have undergone FGM, with that figure reaching 80 to 90% for girls in certain rural districts.⁷⁵

An additional concern is the "medicalization" of FGM, which could undermine efforts to stop the practice. Reports suggest that the awareness of the health risks involved with FGM is not leading parents to abandon the practice but rather to turn to medical professionals to perform the procedure.⁷⁶ Anti-FGM activists report that up to 90% of women in the Kisii community of Southern Kenya are being circumcised illegally by medical professionals.⁷⁷ Government authorities have denied that FGM is taking in place in health facilities.⁷⁸

Performing FGM on children under the age of 18 is outlawed by Section 14 of the Children Act 2001.⁷⁹ This act describes girls who are likely to be forced into FGM as children in need of special care and protection and provides for courts to take action against the perpetrators.⁸⁰ However, the law has been faulted for not providing for punishment for offenders⁸¹ and recent statistics also indicate that the government needs to take further steps to ensure that the law is observed in practice.

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

1. With the introduction of free primary education in Kenya, the average age of primary school students has increased. What governmental efforts have been made to ensure age-appropriate sexual and reproductive health information is reaching all students despite their grade level? Is the government ensuring that a consistent, coherent, and evidence-based message is being transmitted to the students? The government's report to the Committee states that the Ministry of Education has developed a policy to allow schoolgirls who become pregnant to continue their education. What is the specific content of this policy and how widely is it being implemented?
2. What measures are being taken to protect students from sexual violence and harassment at school? What steps does the government plan to take to enable children and adolescents to safely report sexual violations in the community and in school environments? What plans does the government have to collect age-specific data on rape and other cases of sexual violence?
3. What measures are being taken to target adolescent women as a group especially vulnerable to HIV infection? Are they receiving accurate and comprehensive information on prevention and treatment? Are there suitable programs designed specifically for this group? Are the needs of out-of-school adolescents, including married adolescents and those living on the streets, being adequately addressed? How much funding is dedicated to such programs?
4. In light of funding limitations, are integrated service programs being developed to ensure access to comprehensive reproductive health services which address both the need for contraception and STI and HIV prevention? Contraceptives, emergency contraceptives and post-exposure prophylaxis are all listed in national guidelines as commodities that should be readily available. What steps are being taken to make access to these drugs a reality?
5. Access to healthcare services is contingent upon there being adequate health workers in all health facilities including those in rural areas. What measures has the government taken to ensure the recruitment, training, and retention of health workers?
6. In its report to the Committee, the government states that it is supporting an Alternative Rite of Passage Initiative and arresting and prosecuting people who force girls to undergo FGM. How widespread and effective is this initiative? How many arrests and prosecutions of violations of the FGM law have actually taken place? In its report, the government also recognizes the link between FGM and early marriage. In light of this link and the many risks early marriages pose to young girls, what is the government doing to ensure that its marriage laws are revised to prevent the practice? What is being done to address the needs of girls and woman who have already undergone FGM, including their reproductive health care needs?

7. In light of the recommendation from the Human Rights Committee that Kenya should bring its abortion law in to conformity with the International Covenant on Civil and Political Rights, what has Kenya done to liberalize its abortion law and safeguard the lives of women and girls from unsafe abortions? What changes in national legislation is the government planning on taking to bring its abortion laws more in line with international human rights treaties? Is the government taking the necessary measures to ensure proper post-abortion care for adolescents?
8. Are suitable measures being taken to ensure that victims of sexual violence have access to emergency contraception and post-exposure prophylaxis as outlined in the guidelines issued by the Ministry of Health? Is the government committed to providing the funding that will ensure the availability of such commodities in health centers? Are medical professionals and law enforcement officers receiving the necessary training on these guidelines?

There remains a significant gap between the provisions of the Children's Rights Convention and the reality of adolescents' reproductive health and lives. We appreciate the active interest that the Committee has taken in the reproductive health and rights of adolescents and the strong concluding observations and recommendations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Kenyan government's compliance with the provisions of the Children's Rights Convention. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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¹ CENTRAL BUREAU OF STATISTICS (CBS) [KENYA], MINISTRY OF HEALTH (MOH) [KENYA], AND ORC MACRO, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2003 14 (2004) [hereinafter KDHS 2003].

² See e.g., *Concluding Observations of the Committee on the Rights of the Child: Benin*, CRC, 21st Sess., para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); *Concluding Observations of the Committee on the Rights of the Child: Cambodia*, CRC, 24th Sess., para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations of the Committee on the Rights of the Child: Mexico*, CRC, 22nd Sess., para. 27, U.N. Doc. CRC/C/15/Add.112 (1999).

³ See e.g., *Concluding Observations of the Committee on the Rights of the Child: Chad*, CRC, 21st Sess., para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, CRC, 26th Sess., para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Concluding Observations of the Committee on the Rights of the Child: Peru*, CRC, 23rd Sess., para. 24, U.N. Doc. CRC/C/15/Add.120 (2000).

⁴ See e.g., *Concluding Observations of the Committee on the Rights of the Child: Chad*, *supra* note 3, para. 30; *Concluding Observations of the Committee on the Rights of the Child: Colombia*, CRC, 25th Sess., para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Concluding Observations of the Committee on the Rights of the Child: Guatemala*, CRC, 27th Sess., para. 40, U.N. Doc. CRC/C/15/Add.154 (2001).

⁵ See e.g., *Concluding Observations of the Committee on the Rights of the Child: Cambodia*, *supra* note 2; *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, *supra* note 3; *Concluding Observations of the Committee on the Rights of the Child: Guinea*, CRC, 20th Sess., para. 27, U.N. Doc. CRC/C/15/Add.100 (1999).

⁶ Mike Mwaniki, *Sh10bn is Set Aside for Sexual Health Education*, THE NATION (NAIROBI), June 20, 2006.

⁷ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, OAU/SPS/Abuja/3 (2001) 6, http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

⁸ Mwaniki, *supra* note 6.

⁹ See *Concluding Observations of the Committee on the Rights of the Child: Argentina*, CRC, 8th Sess., para. 19, U.N. Doc. CRC/C/15/Add.35 (1995); *Concluding Observations of the Committee on the Rights of the Child: Egypt*, CRC, 26th Sess., para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Concluding Observations of the Committee on the Rights of the Child: Georgia*, CRC, 24th Sess., para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Concluding Observations of the Committee on the Rights of the Child: Latvia*, CRC, 26th Sess., paras. 39-40, U.N. Doc. CRC/C/15/Add.142 (2001); *Concluding Observations of the Committee on the Rights of the Child: Russian Federations*, CRC, 22nd Sess., para. 48, U.N. Doc. CRC/C/15/Add.110 (1999).

¹⁰ Committee on the Rights of the Child, *Gen. Comment No. 4, Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 33rd Sess., para. 31, U.N. Doc. CRC/GC/2003/4 (2003).

¹¹ *Concluding Observations of the Committee on the Rights of the Child: Kenya*, CRC, 28th Sess., para. 46, U.N. Doc. CRC/C/15/Add.160 (2001).

¹² REPUBLIC OF KENYA, DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH, ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY: PLAN OF ACTION 2005-2015 3 (2005).

¹³ *Id.*

¹⁴ KDHS 2003, *supra* note 1 at 130.

¹⁵ *Id.* at 132.

¹⁶ *Id.* at 237.

¹⁷ *Id.* at 61.

¹⁸ *Id.*

¹⁹ *Id.* at 95.

²⁰ *Id.* at 209.

²¹ See *Concluding Observations of the Committee on the Rights of the Child: Concluding Observations of the Committee on the Rights of the Child: Egypt*, *supra* note 9, para. 44; *Concluding Observations of the Committee on the Rights of the Child: Georgia*, *supra* note 9, para. 47; *Concluding Observations of the Committee on the Rights of the Child: Latvia*, *supra* note 9, paras. 39-40; *Concluding Observations of the Committee on the Rights of the Child: Russian Federations*, *supra* note 9, para. 48.

²² KDHS 2003, *supra* note 1, at 106.

²³ *Id.* at 110.

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- ²⁴ *Id.* at 211.
- ²⁵ Jane Godia, *Threatened Lives*, SUNDAY STANDARD, Nov. 14, 2004, at 20; Joyce Mulama, *Contraceptives? You're Lucky if You Get Them*, INTER-PRESS SERVICES, GLOBAL INFORMATION NETWORK, Nov. 8, 2004, available at <http://ipsnews.net/interna.asp?idnews=26165>.
- ²⁶ Mulama, *supra* note 25.
- ²⁷ COLETTE ALOO-OBUNGA, COUNTRY ANALYSIS OF FAMILY PLANNING AND HIV/AIDS: KENYA IV, 15, 16 (2003).
- ²⁸ POPULATION ACTION INTERNATIONAL, ACCESS DENIED: THE IMPACT OF THE GLOBAL GAG RULE IN KENYA 3 (2006).
- ²⁹ *Id.*
- ³⁰ *Id.*
- ³¹ KDHS 2003, *supra* note 1, at 194.
- ³² *Id.* at 221
- ³³ *Id.* at 187
- ³⁴ HORIZONS REPORT: HIV/AIDS OPERATIONS RESEARCH, ABCS: NOT AS SIMPLE AS THEY SOUND: KENYA STUDY HIGHLIGHTS HOW ADULTS AND YOUTH INTERPRET KEY MESSAGES 9 (Dec. 2005).
- ³⁵ *Id.* For example, when asked to define “being faithful,” respondents equated the term with other qualities like “loyalty to another person or being honest and trustworthy” rather than sexual fidelity.
- ³⁶ *Id.* at 10.
- ³⁷ *Kenyan First Lady in AIDS Storm*, BBC NEWS, May 19, 2006.
- ³⁸ UNICEF, EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE, 32, 2005.
- ³⁹ Shelley Clark, *Early Marriage and HIV Risks in Sub-Saharan Africa*, 35 STUD. FAM. PLAN. 149, 150 (2004).
- ⁴⁰ *Id.* at 149.
- ⁴¹ *Id.*
- ⁴² The Children Act of 2001 prohibits the marriage of any child and defines child as being under 18. *See* Kenya Gazette Supplement No. 95 (Acts. No. 8), The Children Act, 2001, §§ 2, 14 [hereinafter Children Act 2001].
- ⁴³ The Marriage Act, Cap. 150 (Kenya).
- ⁴⁴ The Hindu Marriage and Divorce Act, Cap 157 (Kenya).
- ⁴⁵ Vicky W. Mucai-Kattambo, Janet Kabeberi-Macharia & Patricia Kameri-Mbote, *Law and the Status of Women in Kenya*, in WOMEN, LAWS, CUSTOMS AND PRACTICES IN EAST AFRICA – LAYING THE FOUNDATION (Janet Kabeberi-Macharia, ed.) (1995).
- ⁴⁶ Kenya Penal Code, Provision 240. The Ministry of Health, in its guidelines on the care of survivors of rape and sexual violence, has indicated that abortion may be available when pregnancy is a result of rape. However, the legal basis for this policy is not explicit in existing legislation. DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH (KENYA), NATIONAL GUIDELINES: MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE 9 (2004) [hereinafter MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE].
- ⁴⁷ *Kenyan Medics Call for Legalization of Abortion to Reduce Maternal Deaths*, BBC MONITORING INTERNATIONAL REPORTS, Jan. 29, 2004.
- ⁴⁸ *Kenya: Teen Pregnancy Rising Despite AIDS Impact*, UN INTEGRATED REGIONAL INFORMATION NETWORKS, Feb. 23, 2006.
- ⁴⁹ The price for a safe abortion in private facilities in Kenya has been estimated to be approximately \$625 while a “backstreet” abortion can be obtained for a few dollars. Joyce Mulama, *supra* note 25.
- ⁵⁰ *Top KCPE Pupil Dies After Abortion*, EAST AFRICAN STANDARD, Jan. 6, 2005.
- ⁵¹ *Id.*
- ⁵² U.N. Econ. & Soc. Council [ESOSOC], Comm. on Human Rights, Report of the Special Rapporteur: Girls’ Right to Education, para. 78, U.N. Doc. E/CN.4/2006/45 (Feb. 8, 2006) (prepared by V. Munoz Villalobos).
- ⁵³ Human Rights Committee, *General Comment 28, Equality of Rights Between Men and Women* (Article 3), 68th Sess., para. 11, U.N. Doc. CCPR/C/21/Rev/1/Add/10 (2000); 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. Article 14(2)(c) of the Protocol states that 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.” Kenya has signed but not ratified the Protocol.

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