



EXECUTIVE SUMMARY

IN HARM'S WAY

THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW

CENTER
FOR
REPRODUCTIVE
RIGHTS

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OUR MISSION

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

OUR VISION

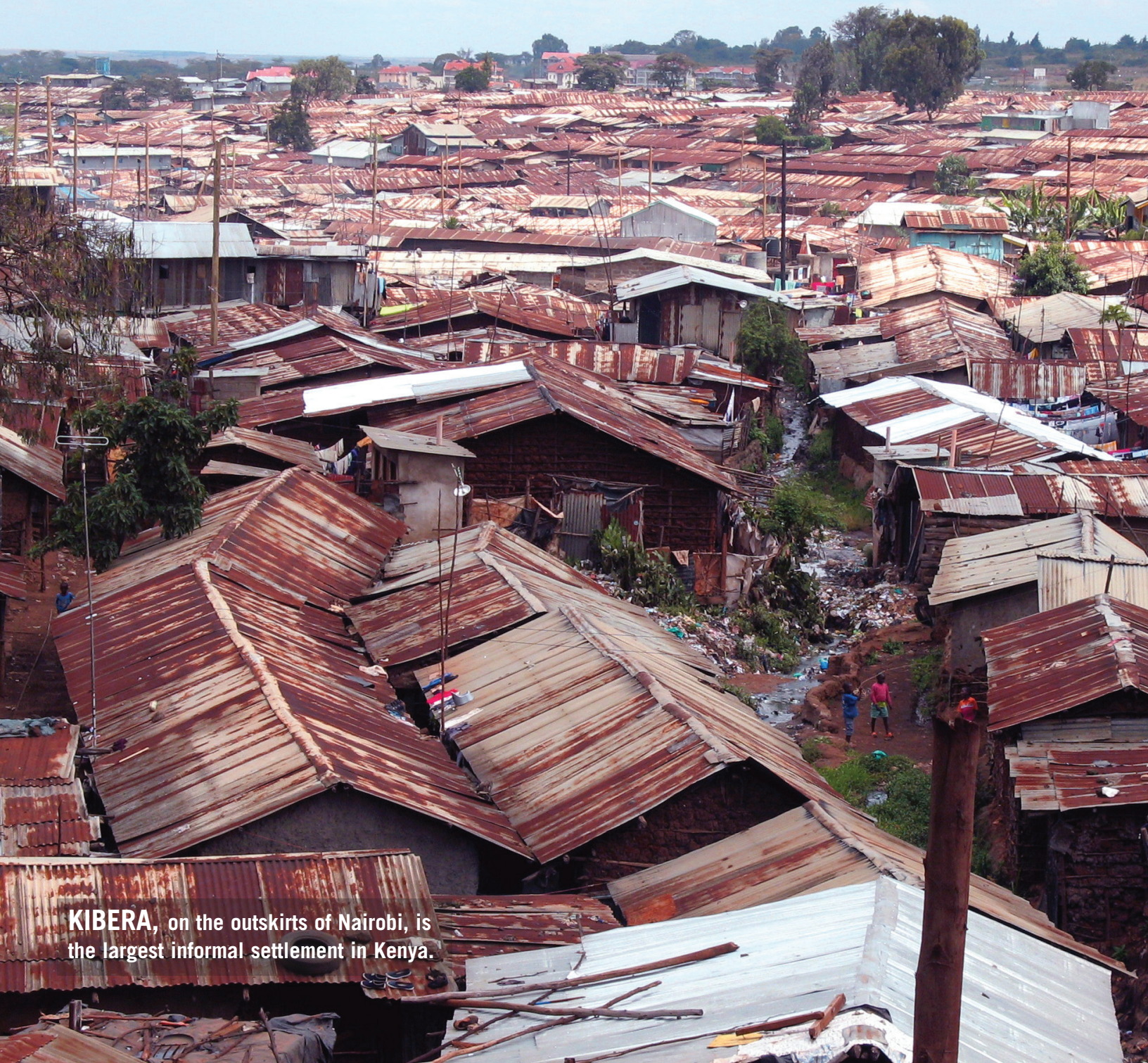
Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.

Research for this Report

The Center for Reproductive Rights has worked on issues related to Kenyan healthcare for several years and issued two previous human rights fact-finding reports documenting 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 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.

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.*

Overview

A Preventable Epidemic of Maternal Mortality from Kenya's Restrictive Abortion Law

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.¹

—**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.² In Kenya, 35% of maternal deaths are attributable to unsafe abortion.³ These deaths are a direct consequence of Kenya's abortion law, one of the most restrictive in the world.

The impact on Kenyan women, girls, and families from the law is devastating. In Kenya, a woman wanting to safely terminate an unwanted pregnancy must negotiate a maze of misinformation as well as personal, financial, and bureaucratic barriers, due to the stigma, lack of legal clarity, and prohibitive costs surrounding the procedure.

Shortcomings in the provision of reproductive health care heighten the risk of unwanted pregnancy, forcing women to turn to unsafe abortion and its life-threatening risks. A lack of contraception and clear information about family planning, combined with intolerably high levels of sexual violence and inconsistent access to emergency contraception, trap women and girls into unwanted pregnancies.

Schoolgirls are particularly vulnerable when faced with unwanted pregnancies and may lose their opportunity to complete their education due to the stigma surrounding adolescent pregnancy. Despite policies in place to prevent this practice, Kenyan schools often expel pregnant girls once their pregnancies are discovered. Girls who risk procuring an often unsafe abortion in an effort to remain in school are also often faced with expulsion, leaving girls facing an unwanted pregnancy with few opportunities to successfully complete their secondary school education.

Criminalization of abortion means that women and girls with unwanted or unplanned pregnancies—even those who could seek a legal abortion—resort to treatment from herbalists and unqualified individuals, seeking medical care only for advanced infections. The cost of treatment for these complications varies widely and can be increased even further by requests for bribes by healthcare providers. In addition, women may find themselves detained in health care facilities if they are unable to pay their medical bills after receiving post-abortion care.

A lack of clarity about legal access to abortion has produced widespread misinformation among medical providers as well, resulting in denials of access to safe abortion even where permitted under

the law. Further, medical centers lack trained personnel and equipment to perform post-abortion care, and the stigma surrounding even legitimate post-abortion care exposes women to verbal abuse and the withholding of available pain management by providers. Those medical providers who do provide services under the law run the risk of arbitrary prosecution by police, shake-downs by extortionists, and public shaming.

The result is an epidemic of maternal mortality that could be prevented with better funding for family planning and provider training, accurate provider and public education on sexual health and the law, and legal reform that better supports providers and improves access to safe abortion.

Our report – a comprehensive look at the full spectrum of failures affecting the reproductive health of women in Kenya – extensively documents the devastating effects of this system upon women, girls, families and providers of medical care, using interviews with officials and medical providers, focus group research, site visits, and a review of relevant laws, guidelines and media reports related to the issue.

As we demonstrate, this failure to protect the lives of women and girls also has consequences under international law, constituting violations of human rights under both the African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol) and treaty interpretations by international human rights bodies. The rights violations documented in this report make clear that the lack of access to safe abortion is responsible for the deaths and health burdens of thousands of women and seriously undermines the quality of care both provided and received in Kenyan healthcare facilities.

While our focus is 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.

Current Kenyan Constitutional Reform Process Includes Consideration of Even More Harmful Abortion Restrictions

The findings presented in this report take on particular importance now, as some in Kenya work to introduce language into its proposed new constitution that may restrict access to safe abortion even further. Language proposed for inclusion in the Bill of Rights states that “the life of a person begins at conception.” An additional proposed clause could prohibit abortion in nearly all cases in Kenya.

Yet this fact-finding makes clear that restrictive abortion laws do not in fact 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 ill-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.

Given the consequences of such restrictions, the inclusion of the language being proposed would fly in the face of the purposes of constitutional reform. 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 needed only by women 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.

The Intolerably High Cost of Unsafe Abortion for the Kenyan Healthcare System and Kenyan Women

The considerable cost of unsafe abortion to 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.

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 or private hospitals only when complications are severe and complex, requiring more resources and extended hospital stays, delay which also extends their suffering and increases their risk of dying from infection or other causes.

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.

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.”⁴ This is a conservative figure—the World Health Organization notes that “[m]ore than any other aspect of sexual and reproductive ill-health, abortion suffers from gross underreporting.”⁵ 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].”⁶

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. Ultimately, reducing the cost burden of unsafe abortion to both women and the healthcare system is simply a matter of providing safe, accessible abortion services. Steps must also be taken to educate providers, adolescents and women about the actual scope of current abortion law, including the availability of post-abortion care and government policies which emphasize its critical role in saving women’s lives. The government must also make clear that post-abortion care is a legal service and that women seeking such care will not be arrested or prosecuted under any circumstances.

Conclusions in Brief

A System in Crisis from Contraception to Post-Abortion Care

CONCLUSION ONE: ACCESS TO CONTRACEPTION IS PRECARIOUS FOR BOTH MARRIED AND UNMARRIED WOMEN

The context:

- Kenyan women experience high rates of unwanted and unplanned pregnancies and have limited access to contraceptives and family planning information.
- According to the 2003 Kenya Demographic and Health Survey (KDHS), “nearly 20 percent of births in Kenya are unwanted and [an additional] 25 percent are mistimed (wanted later).”⁷
- According to the 2009 KDHS Preliminary Report, the modern contraceptive prevalence rate for married women is 39%.⁸ 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 30–34.⁹

Research conclusions:

- **Women encounter multiple barriers to contraceptive access.** Access to contraceptives in Kenya is limited by the government’s failure to ensure an adequate and consistent supply of contraceptives and the effective dissemination of accurate family planning information, financial barriers to contraceptive access, and discriminatory service provision stemming from the stigma surrounding women’s and girls’ sexuality in Kenya.
 - The Kenyan government’s failure to procure sufficient contraceptive stocks has meant that Kenya’s public health facilities have consistently suffered from severe shortages, or “stock-outs,” of contraceptives in recent years.¹⁰
 - The Kenyan government has failed to effectively disseminate accurate family planning information. According to the 2003 KDHS, 25% of women¹¹ and 29% of men¹² had not been exposed to family planning messages through the media, including radio, television and newspapers/magazines, in the months preceding the survey.
 - 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 Kenya Service Provision Assessment Survey (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.¹³ The private sector poses similar financial obstacles to contraceptive access. Although private drug stores do have contraceptives consistently in stock, their prices are often too expensive for most Kenyans.¹⁴

- **A lack of meaningful access to a comprehensive range of contraceptive methods puts women and girls at a greater risk of unintended pregnancy.**
 - 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.¹⁵
 - 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.¹⁶

CONCLUSION TWO: KENYAN ADOLESCENTS ARE ILL-INFORMED ABOUT SEXUAL HEALTH AND LACK ACCESS TO CONTRACEPTION

The context:

- Kenya has high rates of teenage pregnancies and Kenyan youth receive limited sexuality education in schools.¹⁷
- An estimated 5.5 million Kenyan girls between the ages of 15 and 19 give birth annually.
- 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,¹⁸ sex education in secondary schools in Kenya is limited¹⁹ and, in some cases, nonexistent.²⁰

Research conclusions:

- **Lack of information and widespread misinformation about sexuality and reproductive health leads to unwanted pregnancies.** 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.
 - 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.”²¹
- **Adolescents are often unaware of available family planning services.** 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 contraception is free in government facilities.²² 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.”²³

CONCLUSION THREE: UNWANTED PREGNANCY, DISCRIMINATION AGAINST PREGNANT SCHOOLGIRLS, AND ABORTION STIGMA DRAMATICALLY REDUCE EDUCATIONAL OPPORTUNITIES FOR SCHOOL-AGE GIRLS

The context:

- Girls in Kenyan schools are exposed to sexual abuse, receive limited sexuality education—particularly about access to safe abortion, and may be forced to drop out or are expelled by the school administration upon becoming pregnant.
- The lack of sexuality education in Kenyan schools, poor access to information about sexual and reproductive health more generally, sexual coercion and violence 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;²⁴ and 13% of secondary students surveyed nationally had experienced their first pregnancy by age 14.²⁵
- 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 percent of sexual abuses cases never reached the TSC."²⁶
- 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.²⁷ As a result, only 35% of Kenyan girls between the ages of 16 and 20 are still in school, while almost half of boys the same age are, despite the similarity of enrollment numbers when the boys and girls were younger.²⁸

Research conclusions:

- **Pregnant girls cite the stigma of pregnancy and discrimination by teachers and peers as the main reason that they are forced to leave school.**²⁹ Girls who attempt to return to school after pregnancy face humiliation and isolation—according to a 2008 study, fellow students "do not interact with them freely, partly at the instigation of teachers, who view the returning students as a bad influence."³⁰
- **Teachers and school administrators sometimes 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."**³¹ Since the girls may lack strong support systems, they often are not in a position to challenge mistreatment or expulsion.³² According to news reports, at the Mariny 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;³³ 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.³⁴
- **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."³⁵

- **In seeking abortion, young women risk—and sometimes lose—their lives.**
 - o 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.³⁶
 - o 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.”³⁷ Instead, the girls agreed that “the most common way to get an abortion is backstreet and when that fails you go to the hospital.”³⁸
- **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.”³⁹

CONCLUSION FOUR: SEXUAL VIOLENCE AND “SURVIVAL SEX” IS PREVALENT AND LEADS TO UNWANTED PREGNANCIES AND UNSAFE ABORTION

The context:

- High rates of sexual violence in Kenya, particularly during the post-election violence in 2008-09, contribute to unwanted pregnancies.
- 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.⁴⁰
- According to the 2003 Kenya Demographic and Health Survey (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.”⁴¹
- 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%.⁴² The data also indicated a statistically significant relationship between intimate partner violence and unintended pregnancies.⁴³ According to the same study, in Kenya, a slightly higher percentage of abortions are procured by women who have experienced intimate partner violence than by those who have not.⁴⁴

Research conclusions:

- **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

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.”⁴⁵

- o As the Women’s Commission for Refugee Women and Children documented following the post-election violence,

*Cases of women and girls suffering from unsafe abortion had been reported in camps [for internally displaced persons]. 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.*⁴⁶

- **Sexual violence and coercion in schools is a serious problem.** 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.⁴⁷
- **Many poor women and girls turn to “survival sex” out of economic desperation.** Due to the worsening economic situation and devastating economic impact of the post-election violence that left hundreds of thousands of Kenyans internally displaced,⁴⁸ 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.”⁴⁹

CONCLUSION FIVE: EMERGENCY CONTRACEPTION (EC), EVEN FOR VICTIMS OF SEXUAL VIOLENCE, IS LARGELY UNAVAILABLE; ACCESS TO EC IS HINDERED BY DISCRIMINATION AND MISINFORMATION

The context:

- 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.”⁵⁰
- The Ministry of Health’s 2008 EC guidelines for healthcare providers state that “EC is used after unprotected sex” and does not limit the situations in which it can be dispensed.⁵¹ They further state that “EC can be safely used by adolescents.”⁵²
- EC is also supposed to be available free at public health facilities.⁵³

Research conclusions:

- **Many women who have survived sexual violence never receive emergency contraception (EC).** The reasons for this vary. 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. Supplies of EC are also unavailable at hospitals and clinics that are Catholic facilities and those under the Christian Health Association of Kenya.⁵⁴
- **The time period for intervention using EC is sometimes interpreted too narrowly by providers.** Kenya’s Sexual Violence Guidelines state that EC can be given up to 72 hours after rape.⁵⁵ Yet this is inconsistent with the World Health Organization’s recommendations⁵⁶ and the Ministry

of Health’s guidelines on EC, which state that EC should be used “as soon as possible, but within 120 hours of unprotected sex.”⁵⁷ Many of the healthcare providers interviewed for this report asserted that EC had to be administered within 72 hours.⁵⁸

- **Despite the clear public demand for EC, Kenyan public health facilities are insufficiently stocked and face persistent shortages in supply.** Maintaining consistent government stocks of emergency contraception has proven challenging in Kenya.⁵⁹ By the end of June 2009, only 0.3 months’ worth of EC stock remained in government stores, whereas the minimum recommended stock is 10.3 months.⁶⁰
- **Interviews suggest women are being denied EC by providers and pharmacists on the basis of age and marital status and personal perceptions of “abuse” of EC,** despite the fact that these are not valid reasons to withhold EC according to the Ministry of Health’s 2008 EC guidelines for healthcare providers.⁶¹
- **Accounts of arbitrary refusals to provide EC were common from 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.”⁶² This was corroborated by pharmacists. A pharmacist at a family planning center explained that the “reason why [pharmacists] would hold back contraceptives is because the person looks young.”⁶³

CONCLUSION SIX: THE STIGMA OF ABORTION AND ITS CRIMINALIZED LEGAL STATUS IMPERILS WOMEN’S HEALTH

The context:

- Kenya’s Penal Code lays out the penalties for a woman who obtains⁶⁴ an “unlawful” abortion, anyone who acts with the intent to “unlawfully” provide an abortion for a woman, and any person who supplies drugs or instruments to be used in the performance of an “unlawful” abortion.⁶⁶
- The Penal Code can be read as creating a lawful exception to illegal abortion: 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.”⁶⁷ 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.
- 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.⁶⁸

Research conclusions:

- **Women resort to painful and dangerous methods to terminate unwanted pregnancy.** These methods include catheters,⁶⁹ crochet or knitting needles,⁷⁰ sticks,⁷¹ pipes,⁷² coils or wires,⁷⁴ and pens.⁷⁴ Other methods include ingesting dangerous substances or overdosing on medication, such as Jik (bleach) or a bluing agent (similar to bleach),⁷⁵ concentrated tea,⁷⁶ soapy water or detergent,⁷⁷ malaria pills,⁷⁸ and herbs acquired from an herbalist.⁷⁹ Lastly,

some methods involve deliberate bodily injury, such as falling down.⁸⁰

- **Women suffer from life-long complications and disabilities and death as a result of turning to unsafe abortion, including unsafe abortions performed by quacks.** One obstetrician-gynecologist consultant at New Nyanza Provincial Hospital in Kisumu told the Center: “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.”⁸¹
- **Women seeking abortion services sometimes experience degrading treatment by providers, including verbal abuse and the denial of pain medication or anesthesia.** A rape trauma counselor interviewed for this report told of a client 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.”⁸² 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.”⁸³ The woman suffered post-abortion complications from the procedure but refused to seek further care.⁸⁴
- **There are few avenues for redress for women who experience abuses during the provision of abortion-related healthcare services.** 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.⁸⁵
- **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.⁸⁶ 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.⁸⁷
 - o Of these cases not one of the women or girls tried had legal representation at trial.⁸⁸ Ten out of twenty cases examined involved schoolgirls, some of whom were minors.⁸⁹ In all the cases, the women pled guilty to the charges; as the researcher noted, “evidence doesn’t even have to be called.”⁹⁰
 - o 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.”⁹¹

CONCLUSION SEVEN: THE HIGH AND VARIABLE COST OF MEDICAL SERVICES IMPEDES ACCESS TO SAFE ABORTION, EVEN WHEN AVAILABLE UNDER LAW, DISPROPORTIONATELY AFFECTING YOUNG AND POOR WOMEN

The context:

- 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.⁹² Women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya's public healthcare system.
- Poverty affects women disproportionately: female-headed households in Kenya experience higher incidences of poverty than their male counterparts, in both rural and urban areas.⁹³ 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.⁹⁴

Research conclusions:

- **The cost of safe abortion services varies widely.** It ranges from 500 shillings (\$6.50) to 9,000 shillings (\$118.00) from various providers. In contrast, herbalists and unqualified individuals may charge between 300–500 shillings (\$4–6.50) for their services.⁹⁵ A private provider in an informal settlement in Kisumu stated that:

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.⁹⁶

- **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.”⁹⁷

CONCLUSION EIGHT: DESPITE ITS CLEAR LEGALITY AND NECESSITY, SERIOUS BARRIERS IMPEDE ACCESS TO LIFE-SAVING POST-ABORTION CARE

The context:

- The Ministry of Health has made clear that “emergency care for complications of abortion (post-abortion care), both spontaneous and induced, is legal and not punishable by any part of Kenya laws.”⁹⁸ According to its National Post Abortion Care Curriculum, comprehensive post-abortion care is “a life saving procedure that should be available to all women.”⁹⁹ 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 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. 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;¹⁰⁰ 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.

- 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,¹⁰¹ women remain unaware that post-abortion care is a legal service that should be available at government facilities.

Research conclusions:

- **Women requiring post-abortion care must overcome a series of obstacles to access care at a healthcare facility and to obtain quality care from the healthcare providers on duty.** Barriers to access include the fear of prosecution and social stigma and the prohibitive costs associated with obtaining post-abortion 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.”¹⁰²
- **Women delay seeking care because they fear social stigma.** A nurse who works both at a government facility and operates a private practice in Suba District, explained 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.”¹⁰³ 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.
- **In some cases, the fear of stigma is lethal.** 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,”¹⁰⁴ 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.”¹⁰⁵
- **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,”¹⁰⁶ making appropriate care more difficult to determine and risking the health complications of improper post-abortion care treatment.
- **The cost of post-abortion care is a barrier.** According to 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.”¹⁰⁷

- **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.** The medical superintendent of Kisumu East District Hospital reinforced this proposition, asserting that “ignorance . . . that the fee can be waived” prevents women from seeking post-abortion care.¹⁰⁸ Nearly all of the public health providers interviewed, in contrast, mentioned the possibility of a fee waiver.¹⁰⁹
- **Extended care in serious cases can be very expensive.** According to 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).¹¹⁰
- **Women interviewed for this report also 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.”¹¹¹ At another focus group discussion with 19 young women in Mombasa, the consensus was that

*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.*¹¹²

Bribes for post-abortion care services were perceived as common, revealed focus group discussions conducted by the Center for Reproductive Rights with women in Mombasa,¹¹³ Kibera,¹¹⁴ and Mbita¹¹⁵ in Nyanza Province. The precise amount paid in bribes was unknown—“it’s secret,” agreed the women from Mbita.¹¹⁶

- **Patients are sometimes detained in healthcare facilities when they are unable to pay their medical bills for post-abortion care.** 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.”¹¹⁷
- **Detention due to medical debt can further discourage women from seeking post-abortion care and has serious consequences for women and their families.** 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.

CONCLUSION NINE: POST-ABORTION CARE, EVEN WHEN AVAILABLE, IS OFTEN DELAYED, LACKING IN QUALITY, AND CHARACTERIZED BY MISTREATMENT

The context:

- In the year prior to the 2004 Kenyan Service Provision Assessment Survey, only 5% of all service providers interviewed reported receiving in-service training on post-abortion care.¹¹⁸ As a comparison, 25% of service providers reported receiving in-service training on preventing

mother-to-child transmission of HIV¹¹⁹ and 58% participated in a training course related to HIV/AIDS¹²⁰ in the 12 months preceding the survey.

- In 2006, the Ministry of Health drafted a National Reproductive Health Curriculum for Service Providers to address and standardize the various curricula used in training.¹²¹ 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.¹²² However, implementation of the policy has been poor leading not only to continuing confusion over nurses' scope of practice,¹²³ but also to a failure to update existing curricula to comply with its requirements.¹²⁴
- 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."¹²⁵

Research conclusions:

- **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 procedures by untrained providers lacking proficiency, and the absence of pain management.
- **Inconsistent availability of blood in Kenya's blood banks may delay care and increase hospital fees for post-abortion care patients.** A professor of OB/GYN at the University of Nairobi/ Kenyatta National Hospital, 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,"¹²⁷ thereby delaying their care and increasing their hospital bill.
- **Lack of equipment, lack of infection control, and incorrect use of equipment leading to equipment breakdowns all contribute to the lack of availability and low quality of post-abortion care.**
 - 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.¹²⁸
 - The capacity for infection control is limited in Kenyan healthcare facilities: 54% of government facilities, 52% of private-sector facilities, 84% of NGO-run facilities, and 73% faith-based facilities lack the capacity for full infection control, leaving the overall capacity for infection control in Kenya's healthcare system at 40%.¹²⁹
 - Health facilities often face dual problems of a limited ability to sterilize equipment and control infection coupled with an insufficient supply of manual vacuum aspiration kits, creating a high risk of infection and delaying the provision of care. A nurse in a private clinic in Nairobi explained, "one kit is for ten patients so there are risks of infections."¹³⁰
 - In addition, both public and private providers interviewed for this report attributed the insufficient number of MVA kits to the fact that kits were repeatedly breaking down.¹³¹ Experts and practitioners linked the breakdown in kits to a lack of sufficient training.¹³² One reproductive health specialist said that he has seen providers perform MVA

procedures without knowing how to use the kit; he observed one provider trying to do an MVA who “broke three kits in one go.”¹³³ 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 the reproductive health specialist stated, “One wonders what the quality of care would be in such situations . . .”¹³⁴

- **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.**

- o A clinical officer at a public 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.’”¹³⁵ As a result, he noted, most of the patients who experience such verbal abuse do not come back for follow-up care.¹³⁶
- o Such abuse occurs regardless of whether post-abortion care patients have had a spontaneous or induced abortion. A nurse manager of a different district hospital observed that:

*[Women] 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.*¹³⁷

- **In addition to facing verbal abuse, failing to provide women with anesthesia or pain medication while undergoing post-abortion care 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.”¹³⁸

A reproductive healthcare specialist and trainer in manual vacuum aspiration (MVA) decried the practice of denying pain relief:

*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.*¹³⁹

- **Post-abortion family planning counseling is inadequate.** Although “studies in Latin America and Africa have shown that after having an abortion patients will accept contraception at high rates [and that c]ontraceptive counseling and provision at the time of treatment reduced unintended pregnancies and repeat abortions by 50% over 1 year in Zimbabwe, compared with post-abortion patients who did not receive such services,”¹⁴⁰ family planning follow-up is only haphazardly available as part of post-abortion care.

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.”¹⁴¹ The impact of this approach can be seen in the official post-abortion care statistics collected at the same hospital: less than 33% of women who received post-abortion care services between January and June 2009 left with a family planning method.¹⁴² 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.¹⁴³

CONCLUSION TEN: KEY MEDICAL PROVIDERS OF REPRODUCTIVE HEALTHCARE LACK TRAINING, EQUIPMENT, AND CLARITY ON THE LAW AND THEIR SCOPE OF PRACTICE

The context:

- 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.¹⁴⁴ Only 6% of hospitals, maternities, and health centers in Kenya were found to offer comprehensive emergency obstetric services.¹⁴⁵
- 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.¹⁴⁶ Only 11% of all government-managed facilities have the basic components to support 24-hour emergency services.¹⁴⁷
- Kenyan healthcare facilities often lack basic equipment necessary for the provision of post-abortion care and safe abortion, including latex gloves, soap, water, disinfecting solution, sterilization equipment, and the equipment used for post-abortion care.¹⁴⁸

Research conclusions:

- **Nurses lack both 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 mistaken belief among a number of those interviewed is that abortion is illegal, with no exception to preserve the woman’s life or health.¹⁴⁹ 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.¹⁵⁰ The code mentions no exceptions in which procuring an abortion may be considered legal.¹⁵¹
- **Clinical officers lack training and information on abortion law 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.”¹⁵² According to the Clinical Officers Council, which is charged with overseeing clinical officers’ training,¹⁵³ clinical officers are taught the content of the abortion law.¹⁵⁴ However, as with nurses, the educational focus appears to be primarily on the prohibitive nature of the Penal Code provisions. Clinical officers therefore believe the law only applies to the most extreme and indisputable—and therefore rarest—of circumstances. For example, explained a post-abortion care trainer for clinical officers and nurses, “people understand ‘save the woman’s life’ to be if the woman will die in the next five minutes.”¹⁵⁵

- **Doctors, including gynecologists, also remain unclear about legal standards for abortion access.** “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.¹⁵⁶ Similarly, a gynecologist trained at the University of Nairobi explained that they were never taught the law in medical school.¹⁵⁷ 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.”¹⁵⁸
- **Lack of familiarity with the law and policies surrounding abortion can result in healthcare providers themselves creating 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. A study carried out in Nairobi by a gynecologist found that all the recorded therapeutic abortion cases he identified had been performed only after obtaining a written recommendation from a psychiatrist.¹⁵⁹
 - **The Medical Board’s Code of Conduct however does not contain a gynecologist or psychiatrist consultation requirement.** This misinformation can be traced to training schools’ curriculums: one of Kenya’s two medical schools teaches students to seek the written opinion of two medical practitioners, “usually a psychiatrist and another doctor”¹⁶⁰ 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.¹⁶¹
 - **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.** Delaying tactics – or outright denial of services – are not uncommon.¹⁶² A former nurse-manager of the OB/GYN department at Kenyatta National Hospital (KNH) recounted an incident at the hospital:

*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 [incision of the uterus]. 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.*¹⁶³
- **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.** 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.
- **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.** 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.”¹⁶⁴ A clinical officer who practices at a 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].*¹⁶⁵

CONCLUSION ELEVEN: CRIMINALIZATION OF ABORTION STIGMATIZES AND HARMS MEDICAL PROVIDERS WHO PROVIDE ABORTION-RELATED CARE

The context:

- According to the chairman of the Medical Practitioners and Dentists Board [the Board], the statutory body charged with regulating medical and dental practice in Kenya, 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.¹⁶⁶ 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.”¹⁶⁷ 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.”¹⁶⁸
- 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.¹⁶⁹

Research conclusions:

- **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.
- **Healthcare 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.¹⁷⁰
 - 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.

- **Con artists also prey on providers. Members of the public are using providers’ vulnerability to public scorn 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 in late 2009, when individuals claiming to be police officers from the Central Police Station and journalists from a television station 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.¹⁷¹

Conclusion

Immediate Steps are Needed to Improve Reproductive Health for Women, Girls, and Families in Kenya

As this report demonstrates, when 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 Kenya’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.

The report offers a comprehensive look at the corrosive effects of criminalizing abortion. 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.

Reform is needed to address the problem of unsafe abortion and low-quality abortion care. The following section provides recommendations for concrete steps that would dramatically improve—and save—the lives of women and girls in Kenya.

HUMAN RIGHTS IMPLICATIONS

Key Human Rights Treaties and Bodies Affirm the Importance of Safe and Legal Abortion Services and Quality Post-Abortion Care

- The African Charter's Protocol on the Rights of Women in Africa (Maputo Protocol) has affirmed the importance of safe abortion services in cases of sexual violence, threats to the mental and physical health or life of the pregnant women, and serious fetal anomaly.¹⁷²
- International human rights bodies have recognized that the denial of access to safe and legal abortion and post-abortion care violates a range of human rights, including the right to be free from torture and cruel, inhuman, or degrading treatment, and the rights to life and health.
 - For example, the Committee against Torture which oversees compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has urged countries which restrict access to voluntary abortion, particularly in cases of rape, to consider creating exceptions to the criminalization of abortion. The Committee has recognized that “prohibitions of abortion . . . even in cases of rape [and] incest” cause mental suffering, entailing “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.”¹⁷³ Further, in the context of post-abortion care, the Committee against Torture has stated in concluding observations that “[i]n accordance with World Health Organization guidelines, the State party should ensure immediate and unconditional treatment of persons seeking emergency medical care.”¹⁷⁴
- When discussing the right to health generally and for adolescents in Kenya, the Economic, Social and Cultural Rights Committee which oversees state compliance with the International Covenant on Economic, Social and Cultural Rights,¹⁷⁵ and the Children's Rights Committee which oversees state compliance with the Convention on the Rights of the Child,¹⁷⁶ 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.¹⁷⁷
- Regarding the right to life, the Human Rights Committee has made clear that measures to protect the right to life in the International Covenant on Civil and Political Rights should 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.”¹⁷⁸ The Committee recognizes that illegal and unsafe abortion violates a woman's right to life,¹⁷⁹ and has linked illegal and unsafe abortions to high rates of maternal mortality.¹⁸⁰ In its concluding observations for Kenya, pertaining to the right to life, the Human Rights Committee has expressed “concern about the high maternal mortality rate prevalent in the country, caused, inter alia, by a high number of unsafe or illegal abortions.”¹⁸¹

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 discharging patients.
- **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 of the fact 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 high-quality and safe abortion services and post-abortion care.**

- When conducting 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 that 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 that there is 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, or 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 trainers in non-governmental organizations (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 the 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 responsible for collecting health data:

- **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 the policy 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, as a minimum step 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 in which 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, through the steps below.**
 - 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, as a minimum step 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 (the Maputo Protocol).
 - Enact laws to domesticate, or implement at the national level, 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 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 KENYA NATIONAL COMMISSION ON HUMAN RIGHTS (a body entrusted by law to investigate human rights violations, inform and educate the public about human rights, and recommend to Parliament measures to improve 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 by taking the steps below.**
 - 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 that there are 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.
 - Provide 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.
 - Make arrangements for coordinated staff transfers so there are always a core set of qualified providers capable of offering abortion and post-abortion care services on staff in each facility.
 - Secure 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 may seek redress for violations of their rights in the context of healthcare delivery.
- Use these mechanisms to 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 the practice of 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.

To the Nursing Council (a body charged by law to develop the curriculum and courses of training for nurses, regulate their conduct, and establish professional standards):

- **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 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.**

To the Clinical Officers Council (a body charged by law with overseeing clinical officers' training, regulating their conduct, and taking disciplinary measures when professional misconduct occurs):

- **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 manual vacuum aspiration, 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.

To the Medical Practitioners and Dentists Board (a body charged by law with establishing standards for the medical profession, making provisions for the training and instruction of medical practitioners, and overseeing the conduct of medical practitioners, including by taking disciplinary measures to ensure proper conduct):

- **Clarify and amend the Code of Conduct provision on termination of pregnancy to ensure greater access to safe abortion services.**
 - Replace the language implying 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 manual vacuum aspiration 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 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 (charged with overseeing countries' compliance with key international human rights treaty obligations either from a thematic perspective or in the context of a particular country):

- **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, (which interpret key human rights treaties and oversee state compliance):

- **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 groups advocating for reproductive rights, including the right to safe abortion. •

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 120 *Id.* at Appendix B, Table A-7.5, 301.
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 122 *Id.* at foreword, ix.
 123 Interview with Program Officer, National Nurses Association of Kenya, Tsavo, June 24, 2009. Interview with Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009; interview with Senior Lecturer in Obstetrics and Midwifery, Lecturer in Obstetrics and Midwifery and OB/GYN, Senior Lecturer in Medical/Surgical Nursing, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.
 124 Interview with David Wambuku, Education Officer, and Frederick Ochiemo, Education Officer and Deputy Registrar, Nursing Council of Kenya, Nairobi, July 20, 2009; interview with Senior Lecturer in Obstetrics and Midwifery, Lecturer in Obstetrics and Midwifery and OB/GYN, Senior Lecturer in Medical/Surgical Nursing, Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.
 125 *MOH Post Abortion Care Trainer's Manual* at §1, 27 (2003).
 126 Interview with Professor of OB/GYN, University of Nairobi/Kenyatta National Hospital, Nairobi, Aug. 10, 2009.
 127 *Id.*
 128 2004 KSPAS at Survey Appendix B, Table A-6.36, 287.
 129 2004 KSPAS at Table 6.6, 131.
 130 Interview with Nurse, Private Practice, Nairobi, June 30, 2009.
 131 *E.g.*, interview with Nurse-Midwife/Clinic Owner, Private Clinic, Dandora Phase I, July 3, 2009; interview with Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009; interview with Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
 132 Interview with reproductive health expert, Nairobi, Nov. 2, 2009; interview with Executive Director, Kisumu Medical and Educational Trust, Kisumu, Nov. 2, 2009; interview with Professor of OB/GYN, University of Nairobi, Nairobi, Nov. 3, 2009.
 133 Interview with reproductive health expert, Nairobi, Nov. 2, 2009.
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 142 From Statistics Office at Kisumu District Hospital – referred there by Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009.
 143 *Id.*
 144 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.
 145 *Id.* at 148. 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. *Id.* at 147.
 146 *Id.* at 33.
 147 *Id.*
 148 2004 KSPAS at Table 6.6, 131, Appendix B, Table A-6.32, 283, Appendix B, Table A-6.36, 287.
 149 Interview with Nurse, Nyalenda, Kisumu, July 9, 2009; interview with Nurse, Mbita, July 6, 2009; interview with Nurse, Mbita, July 6, 2009; interview with Nursing Officer, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
 150 Nursing Council of Kenya, Code of Ethics and Professional Conduct for Nurses at 21 (Mar. 2006).
 151 See Nursing Council of Kenya, Code of Ethics and Professional Conduct for Nurses (Mar. 2006).
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 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. See generally Clinical Officers (Training, Registration and Licensing) Act, Cap. 260 of the Laws of Kenya (Revised ed. 1990).
 154 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.
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 156 Interview with Doctor, not-for-profit private clinic, Kisumu, July 9, 2009.
 157 Interview with Gynecologist with private practice in Nairobi, June 30, 2009.
 158 Interview with Chief Administrator, New Nyanza Provincial Hospital, Kisumu, July 28, 2009.
 159 Interview with Gynecologist with private practice in Nairobi, June 30, 2009.
 160 Interview with Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.
 161 Interview with Senior Lecturer in Obstetrics and Midwifery; Lecturer in Obstetrics and Midwifery and Obstetrician and Gynecologist; Senior Lecturer in Medical/Surgical Nursing; and Acting Director of the School of Nursing, School of Nursing, Nairobi, Aug. 5, 2009.
 162 Interview with Professor of OB/GYN, University of Nairobi/KNH, Nairobi, Aug. 12, 2009; interview with Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009; interview with Professor of OB/GYN, Moi University, Nairobi, June 29, 2009.
 163 Interview with Executive Director, Kisumu Medical and Educational Trust, Kisumu, July 28, 2009.
 164 *MOH Post Abortion Care Trainer's Manual* at §1, 37 (2003).
 165 Interview with Clinical Officer, Kisumu East District Hospital, Kisumu, July 27, 2009.
 166 Interview with Professor Julius Kyambi, Chairman, Medical Practitioners and Dentists Board, Nairobi, July 13, 2009.
 167 *Id.*
 168 Interview with Daniel Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board, Nairobi, July 1, 2009.
 169 Interview with Evelyne, Kibera, July 11, 2009.
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- ¹⁷⁹ 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).
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- ¹⁸¹ Human Rights Committee, Concluding Observations, Kenya, para. 14, U.N. Doc. CCPR/CO/83/KEN (2005).

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.