CENTER FOR REPRODUCTIVE RIGHTS

May 13, 2013

United Nations Committee against Torture
Office of the United Nations High Commissioner for Human Rights
Palais des Nations
CH-1211 Geneva 10
Switzerland

Re: Supplementary Information on Kenya, scheduled for review by the U.N. Committee against Torture during its 50th session (May 2013)

Honorable Committee Members:

This letter is intended to supplement the 2nd periodic report of the Government of Kenya, scheduled for review by the Committee against Torture (the Committee) during its 50th session. The Center for Reproductive Rights (the Center) with headquarters in New York and a regional office in Kenya is an independent non-governmental organization that uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill. The Center hopes to further the Committee's work by providing information concerning the rights protected in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention or CAT).

The right to be free from torture and cruel, inhuman and degrading treatment or punishment (hereinafter torture and ill-treatment) is a non-derogable right[1] that is recognized in multiple international human rights instruments which Kenya has ratified. These include CAT,[2] the International Covenant on Civil and Political Rights and the African Charter on Human and Peoples' Rights.[3] The right not to be subject to physical or psychological torture and treated in a cruel, inhuman or degrading treatment is also enshrined in the Constitution of Kenya.[4] In order to ensure this right, states are obligated to eliminate any legal or other obstacles that impede the eradication of torture and ill-treatment[5] and take measures to effectively prevent it, including legislative, administrative, judicial or other actions.[6]

This Committee, in General Comment 2, has acknowledged that the contexts in which torture and ill-treatment occur, and the scope and nature of the prohibition are evolving through time.[7] The Committee has specifically recognized that women face heightened risk of torture and ill-treatment in different contexts, including through "deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes."[8] Similarly, the United Nations Special Rapporteur on Torture has stated that "[i]nternational and regional human right bodies have begun

120 Wall Street, 14th Floor
New York, New York 10005
Tel. 917 637 3600 Fax. 917 637 3666
www.reproductiverights.org

to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering inflicted on the basis of gender."[9]

We wish to bring to the Committee's attention the following two areas of particular concern: the long-term and continued practice of detention and abusive treatment of women in hospitals while seeking maternal health services; and lack of access to abortion even in instances of rape and post-abortion care. These issues are clear violations of the right of women and adolescent girls in Kenya to be free from ill treatment, which the Kenyan Government has an obligation to fulfill.

1. <u>Detention of Women in Health Care Facilities after Childbirth Under Conditions That Amount To Ill-Treatment</u>

Under Article 16 of CAT, the Kenyan Government is required to ensure freedom from acts of ill-treatment, as any such act is "an offence to human dignity."[10] Article 29 of Kenya's Constitution also prohibits ill-treatment.[11] According to General Comment 2 of the Committee against Torture, ill-treatment, as compared to torture, "may differ in the severity of pain and suffering and does not require proof of impermissible purposes."[12] In order to constitute degrading treatment, however, it is sufficient to show that an act was aimed at humiliating the victim, regardless of whether severe pain was inflicted.[13] General Comment 2 emphasizes that states parties are obligated under CAT to identify, prevent, and punish torture and ill-treatment.[14] It specifically provides that governments have the responsibility to prevent torture and ill-treatment in hospitals—both public and private.[15] In its 2009 concluding observations for Kenya, this Committee expressed concern about occurrences of arbitrary arrest, torture and ill treatment of those in police custody, the dire detention conditions in these detention centers[16] as well as inadequate human rights training programs for health personnel. This Committee also expressed concern about the lack of access to justice in Kenya, particularly for those without economic resources.[17] The practice of detaining women for inability to pay medical fees is a practice that has been going on for years in Kenya and continues to this day.[18] Patients are illegally detained against their will until they pay or until the health care facility is satisfied that they cannot pay.[19] The practice is also widespread and occurs all over the country in both public and private facilities.[20] Private facilities use detention to pressure patients' relatives to pay the bills, while public facilities use detention for this purpose, and also to determine whether a patient is poor enough to qualify for a waiver of fees. While detained, women who have only recently given birth may be forced to sleep on the floor or share a bed with others, deprived of sufficient food, and suffer verbal abuse from staff over their failure to pay.[21] For women whose babies have died, there is a particular psychological cruelty to being detained in a maternity ward, surrounded by other mothers and their infants.

These were the key findings in a fact finding report that was published by the Center and the Federation of Women Lawyers-Kenya (FIDA-Kenya) in 2007—*Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*.[22] Based on these findings, both organizations filed a formal complaint with the Kenya National Commission on Human Rights (KNCHR) in 2009, and this led to the KNCHR's first-ever public inquiry into the violations of women's rights when seeking reproductive health care in the country, the results of which were published in 2012.[23] The KNCHR's inquiry confirmed the ongoing existence of the detention and abuse of women in health care facilities after childbirth for failing to pay their bills in full, and urged the government to address this serious problem.[24]

Despite the public inquiry by the government's own national human rights commission, and recommendations to the government to end the practice, the detentions and abuses continue unabated, and without any efforts to prevent further detentions and to punish perpetrators.

At a focus group discussion which the Center and the Kenya Network of Grassroots Associations organized in March 2012, 23 of the 26 women who participated in the discussion, stated that they were detained after giving birth for not paying their bills at Pumwani Maternity Hospital (Pumwani), which is the largest hospital in Kenya.[25] Most of the women were detained for durations of between two weeks and two months.[26] The majority of them also reported that they were not released until after someone paid the hospital fees on their behalf or advocacy groups intervened.[27] One woman was detained for nine months with her baby and was not released until she went on a hunger strike.[28]

Most women who are detained are denied post-natal and other crucial medical care. For instance, one woman was denied care even though her surgical wounds were bleeding.[29] Another woman reported being subjected to "abusive and frustrating statements."[30] The detained women— whose newborns are most often also detained with them—are not provided with basic necessities: one casual worker in a district hospital, in describing the situation of women detained in the hospital, revealed that at times three women were forced to share one bed since all the beds were occupied and women who had been detained for a long time had to struggle to get food.[31]

M.A., a mother of five children who was admitted at Pumwani stated that "The hospital staff insisted that I had to pay a deposit before being admitted. I gave birth about 15 minutes later and I am horrified to imagine what would have happened if I did not have the deposit demanded."[32] Although M.A. was technically "discharged" immediately, she was not able to pay the remainder of her bill and was detained in the hospital for three weeks and five days. She describes her period of detention as the lowest point of her life. "I was verbally abused by the nurses. I had to sleep on the floor whenever the hospital admitted more patients. I never got a change of hospital gown and beddings. And my children who were all alone in the house had to cater for themselves."[33]

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

Most of the women who were detained had other children who had been left at home with no one to look after them. As a result, many experienced continuous psychological distress during detention because they did not know whether their children had basic necessities such as food and medicine. While some of the women had relatives or friends to look after their children, many were single mothers and their children went without care during the entire length of detention.[36]

In its submission to the Committee, Kenya asserts that "to ensure that poor patients are not marginalized in the provision of health service including cases of child delivery, public hospitals assess their socio-economic situation through social workers . . . [t]hus, public hospitals no longer detain nursing mothers who are unable to pay medical bills after delivery."[37] The stories above confirm that this claim is incorrect. Due to the government's failure to uphold its obligations despite its long-term existence, the recommendations in our fact-finding, and the results of the public inquiry the Center filed a case in December 2012 against the Attorney General and others, in the Kenyan High Court, on behalf of two of the women who were detained and subjected to ill-treatment at Pumwani Maternity Hospital.[38] The case is yet to be heard by the court.

2. Abuse and Neglect of Women Seeking Reproductive Health Services in Health Facilities

This Committee, in previous concluding observations, recognized that the denial of reproductive health services and the abuse and mistreatment women face when seeking such services "can cause tremendous and lasting physical and emotional suffering."[39] The Committee also expressed concern about the denial of medical care for women[40] and urged governments to "take whatever legal and other measures are necessary to effectively prevent acts that put women's health at grave risk, by providing the required medical treatment. . . ."[41] As noted above, the Special Rapporteur on Torture has elaborated that acts aimed at humiliating the victim, regardless of whether severe pain has been inflicted, may constitute degrading treatment or punishment because of the incumbent mental suffering.[42] He also explicitly affirmed that the denial of pain relief constitutes ill-treatment if it causes severe pain and suffering.[43]

Women seeking reproductive health services in Kenyan hospitals often face humiliation and mistreatment which can cause tremendous and lasting physical and emotional suffering and infringe on women's physical and psychological integrity.[44] The fact-finding research conducted by the Center and FIDA-Kenya, and which led to the public inquiry by the KNCHR in 2012, documented systematic abuses with the provision of reproductive health care services, including physical and verbal abuse for women seeking maternity services, and rough treatments during labor.[45] Women recounted rough, painful, and degrading treatment during physical examinations and delivery, as well verbal abuse from nurses if they expressed pain or fear.[46] The research also found delays in medical care during labor or while waiting for stitches after delivery, including being stitched without anesthesia, causing women to endure excruciating pain.[47]

One woman, who gave birth at St. Mary's, a private hospital was subjected to verbal and physical abuse by a medical provider during delivery.[48] During delivery, the medical provider treated her so roughly that she feared for her and her baby's life. However, she was already in labor, and in this extremely vulnerable state, she was unable to react to stop the abusive treatment. He further subjected her to terrible pain and suffering by mutilating her genitals with a sharp object without her consent.[49] As of 2013, she has not obtained redress for the abuse and ill-treatment she suffered in the hands of the health care provider even though she reported the incident to the police, hospital authorities, as well as Kenya Medical Practitioners and Dentists Board. FIDA-Kenya field a case in a Kenyan High Court on behalf of the woman, and the Center was admitted as amicus curiae, but the case has been unduly prolonged and is still pending.

Another woman who delivered in Kitale District Hospital recounted the amount of pain and discomfort she endured during the stitching process: "When stitching was done it was like they were stitching a sack. I complained but they said they were organizing me. They stitched me badly till my backside. I couldn't go for a long call properly for two years."[50] Felicity, who delivered twice at Pumwani said: "The stitching is a very bad experience as the person who does it shouts at you and pulls your legs apart. They keep on shouting at you as if you should know what you are supposed to do."[51] A doctor at the hospital confirmed that women are not treated with dignity during the stitching process. "It's like a conveyor belt—people just quickly stitching them" he said. "The personal touch is not there."[52] Some facilities do not provide women with anesthesia during the very painful stitching process.[53] Betty recalled having to fight for painkillers when she needed stitches after delivery at a hospital in Kisumu. Another woman who required many stitches after a fellow patient helped her deliver at Pumwani said, "I then went and sat on a bench for an hour. . . . I became very sick and asked for a painkiller. They refused and I had to send a cleaner to buy it for me from outside."[54]

Grace, who went to Pumwani Maternity Hospital to give birth, also described the ordeal she faced in the hands of the nurses.[55] When she arrived at the hospital already in pain, she was told to find her own way to the delivery ward and had to lift herself onto the maternity bed.[56] One nurse even cruelly told her to "stop pretending to be in pain."[57] Even when her pain got worse, she was told to continue suffering

because she was responsible for her pregnancy.[58] When the pain got intense, she had to crawl to the nurses to ask for help, but was ridiculed and asked whether she was "exercising."[59]

This ill treatment is exhibited by providers across the spectrum including doctors, midwives, nurses, and other staff in both public and private facilities—although the problem is particularly prevalent in government hospitals, especially Pumwani.

In its 2012 report regarding its public inquiry, the KNCHR found that complications and death related to obstetric care in Kenya hospitals are usually due to negligence and malpractice,[60] and recommended that the government make the establishment of a complaint mechanism in health facilities mandatory and develop a guideline to facilitate this.[61] The Government of Kenya has not implemented this recommendation and the abuse and neglect of women continues in the hospitals.

By failing to prevent the continuation of this ill-treatment of women in health care settings, the government has failed in its obligations under CAT to eliminate any legal or other obstacles that impede the eradication of torture and ill-treatment[62] and take measure to effectively prevent it, including legislative, administrative, judicial or other actions.[63] Although the government, in its report to this Committee, states that it "does not condone the abuse of mothers who seek reproductive health services in hospitals" and that women who have suffered such abuse have the right to report the abuse to the Commission on the Administration of Service or to the respective hospital's Medical Superintendent, there is no evidence to show that these mechanisms are actually effective. Interviews conducted by the Center and FIDA-Kenya with medical providers, patients, and regulatory bodies also revealed that women who have suffered ill-treatment in health care facilities have limited avenues of recourse.[64] Indeed, this was the case for M.N.N. as discussed above.

Kenyan law does not require health institutions to establish a formal internal complaint mechanism—and most often such institutions do not provide any internal avenues for redress.[65] For those that do, there are serious delays in resolving cases—in some instances taking as much as two years.[66] There is also a lack of public awareness about the rights of patients and the mechanisms outside of the health care facilities that are available to enforce them.[67]

3. Lack of Access to Safe and Legal Abortion, Including for Victims of Sexual Violence

This Committee and the United Nations Special Rapporteur on Torture have recognized that restrictive laws that limit access to safe abortion can amount to torture and ill-treatment.[68] Further, this Committee and other international treaty monitoring bodies have repeatedly recognized that forcing a woman to carry to term a pregnancy as a result of rape is a violation of the right of women and can amount to ill-treatment.[69] The Committee has stated that "[f]or the women [survivors of sexual violence who are unable to access legal abortion] [the] situation entails constant exposure to the violation committed against her and causes serious traumatic stress and a risk of long-lasting psychological problems such as anxiety and depression."[70] In its concluding observations, the Committee has also made recommendations for changes in abortion laws to allow for abortion in cases of sexual violence as a means of relieving such trauma.[71]

While the Constitution of Kenya was amended in 2010 to allow for abortion in situations where the health of a woman is at risk—the penal code which criminalizes abortion had only provided for one exception, which is to save a woman's life[72]—it still does not allow for abortion in situations where the woman became pregnant as a result of rape or incest, or when there is fetal impairment. Such restrictions force women to resort to clandestine abortions, which are often unsafe, subjecting women to grave pain and suffering.

The absence of an exception for cases of rape is particularly problematic in light of the high prevalence of sexual violence in Kenya. Even though the incidences of sexual violence are under-reported and there are

no comprehensive researches assessing the exact number of pregnancies that resulted from sexual violence, various researches indicate that the problem is pervasive. A 2006, hospital-based statistics indicated that approximately 16,500 cases of rape occurred each year.[73] A 2008 United States Agency for International Development study indicated that a statistically significant relationship exists between intimate partner violence and unintended pregnancies.[74] A 2009 report found that 16,400 cases are reported every year and "sexual assault cases constitute 50 per cent of offences reported to the [police]."[75] Another study conducted in 2009 also estimated that 12,660 girls were sexually abused by their teachers in Kenya between 2003 and 2007.[76] Further, a 2010 fact-finding research that was undertaken by the Center documented the story of a young woman, brutally raped by two men and genitally mutilated, who subsequently became pregnant.[77] The research also found that sexual violence in schools is wide spread—at least one in twenty boys in high school reported coercing girls into sex and the same number of boys admitted to impregnating a girl.[78] In 2012, a survey concluded that nearly one in three girls in Kenya experience sexual violence before they reach the age 18.[79] As recently as March 2013, the Gender Minister reported that 32% of females in Keya have experienced sexual violence.[80]

Due to various reasons which include financial, infrastructural and institutional barriers, women who are sexually abused have limited or no access to resources, such as emergency contraception (EC), to prevent pregnancies.[81] Some women do not seek medical attention due to lack of reliable transportation to health facilities, including ambulances, while others do not seek health care due to the stigma associated with sexual violence and rape.[82] Even after seeking medical care, women are still not able to access EC due to reasons such as stock-outs, inadequate knowledge of providers about the method, and health care facilities not providing the method for religious reasons.[83]

With the inaccessibility and unavailability of preventative services, women do not have any other recourse but to either continue with the pregnancy—thereby living through the constant reminder and trauma of the violence—or seek unsafe abortion, risking their lives and health. This Committee in expressing concern over similar laws without rape exceptions has stated that "[such laws] severely restrict[ ] access to voluntary abortion . . . leading to grave consequences, including the unnecessary deaths of women."[84] Indeed, in its 2012 public inquiry, the KNCHR found that women resort to "crude methods," administered by unqualified persons to terminate pregnancies, due to lack of abortion services in Kenya.[85] The KNCHR further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya.[86]

This Committee has raised concerns regarding such kind of uncertainty in abortion laws. In its concluding observations on Ireland in 2011, the Committee emphasized that the lack of clear guidelines for when to apply the abortion ban exception "leads to uncertainty for women and their medical doctors, who are also at risk of criminal investigation or punishment if their advice or treatment is deemed illegal."[87] This Committee further recognized that this lack of legal clarity "leads to serious consequences in individual cases" and urged Ireland to establish clear statutory guidelines for legal abortion and adequate service provision to ensure compliance with the CAT.[88] The Committee stated that acts resulting from this lack of clear guidance may amount to torture or ill-treatment.[89]

Even in situations where abortion is legal, women in Kenya do not have access to safe services due to the lack of clarity of laws regarding abortion, lack of training for providers, the stigma around performing abortion, criminal penalties attached to performing illegal abortions, and fear of prosecution for performing even legal abortions.[90] The Penal Code has not been amended to reflect the change in the 2010 constitution, and abortion remains a criminal offence unless done to save the life of the mother under the Code.[91] Additionally, while the 2012 *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya* does not address the issue of abortion in situations where the pregnancy was as a result of rape or incest, or for fetal impairment, the 2004 *National Guideline on the*

Medical Management of Rape/Sexual Violence provides that "[t]ermination of pregnancy is allowed in Kenya after rape" since it is allowed under the 2006 Sexual Offences Act.[92] This situation creates uncertainty among providers and women and leads some providers to refuse to perform legal terminations when requested.[93]

The government's failure to ensure access to safe and legal abortion, including for victims of sexual violence, and to address the existing uncertainties have sustained the high levels of unsafe abortion-related injuries and death in the country. A 2012 study of women treated for post-abortion complications estimates that more than 300,000 abortions occur in Kenya each year.[94] It further found that Kenyan women commonly obtain abortions using unsafe methods and unqualified providers,[95] and "that as many as 60% of all gynecologic emergency hospital admissions are due to" complications from unsafe abortion.[96] It concluded that the numbers of maternal death due to unsafe abortion is high.[97] The Center's 2010 fact finding also found that unsafe abortion is responsible for the deaths of thousands of Kenyan women every year.[98] At least 2,600 women die from complications relating to unsafe abortions annually.[99]

4. Lack of Access to Post-Abortion Care

Denial of post-abortion care (PAC) can lead to serious human rights violations, including health complications, resulting in severe physical or mental suffering.[100] As stated above, complications that arise from unsafe abortions are one of the leading causes of maternal mortality and morbidity in Kenya. This Committee has consistently spoken out against violations of reproductive rights that occur with regard to PAC. In its 2011 review of Paraguay, the Committee expressed concern "about the denial of medical care to women who have decided to have an abortion, which could seriously jeopardize their physical and mental health and could constitute cruel and inhuman treatment."[101] In its recommendations to Chile on access to PAC, the Committee called upon the government to "ensure immediate and unconditional treatment of persons seeking emergency medical care."[102]

This Committee has further expressed concern over situations where life-saving medical care for women suffering complications from illegal abortions had been withheld until they provided information on the individual who performed the abortion. For instance, the Committee called upon the Government of Chile to "eliminate the practice of extracting confessions for prosecution purposes from women seeking emergency medical care as a result of illegal abortion."[103] The Committee also urged the Chilean Government to "investigate and review convictions where statements obtained by coercion in such cases have been admitted into evidence, and take remedial measures including nullifying convictions which are not in conformity with the Convention [against torture]."[104] This Committee has also made similar statements regarding a law that obligates physicians to report women seeking post-abortion health services to the authorities.[105]

Despite the government's Post-Abortion Trainer's Manual's recognition that "prompt treatment of [PAC] should be available,"[106] the health service is not available or is not easily accessible to women in Kenya. One key reason for its being inaccessible is women's fear of harassment by the police and possible prosecution.[107] Also, although the government has clarified that post-abortion care "is legal and not punishable by any part of Kenya laws,"[108] this declaration only offers protection to the health care providers and not to women who seek PAC.[109]

The Center's fact finding research confirmed that fear of prosecution deters women in Kenya from seeking PAC. One woman who delayed seeking care after abortion recounted "I bled for one week and had discharge. But I didn't go to the doctor before that because I was fearing that the doctor could forward my case [to the legal authorities]. So I sat home fearing. When the bleeding stopped and I could

see there was some infection, that is when I decided to go."[110] One nurse who runs a maternity hospital that provides PAC revealed that "there is a lot of threatening and mistreatment by the police."[111] There have been situations where the police went to a clinic and picked up women who they thought were there for PAC.[112] One nurse also described the case of a woman who was brought to the clinic by the police: "They get a report from the neighbors who say this lady was pregnant and now we are not seeing any pregnancy. So the police bring her to the hospital, she is treated and after she has recovered she is taken to the police station to be tried. These cases… [occur] once every three months. The police keep guard over the woman because she might escape so even if she is going to sleep in the ward for three days the police will just be there . . . When she has been treated and recovered they take her to the police station."[113] Accordingly, it is not surprising that another nurse said that "the women would come to their facility only when they are badly off and about to die."[114]

The 2012 public inquiry conducted by the KNCHR also documented a story of a woman who was held in a police station after procuring an unsafe abortion and died after she developed post-abortion complications at the police station but was not taken to a health facility on time to receive PAC.[115]

Even when women overcome their fear of prosecution and seek PAC services, it may be unavailable. The public inquiry conducted by the KNCHR, as well as the Center, found that scarcity of trained providers is one major obstacle to accessing PAC. Out of the 180 health care providers eligible to be trained at the Kisumu East District Hospital in 2010, only ten were trained in PAC.[116] Provider's attitude towards women who have undergone abortion is also another major contributory factor. One woman observed that: "if you go to a government hospital [for post-abortion care], the nurses would harass you. They would say, 'You asked for it.' . . . The government will tell you to go back to where you got the abortion. They will not treat you right way."[117]

Confirming this, a nurse manager of one district hospital stated that: "The ones who may need services may prefer not to come to the hospital. The attitude of the staff is wanting. They treat any patient, even if miscarriage naturally occurred, as criminal. Patients are reluctant to come because they don't want to be abused. The reception of patients is wanting. Attitudes need to change. Any abortion [spontaneous or induced] is treated as criminal until proven otherwise."[118]

Another clinical provider further confirmed this abuse noting that some nurses would say to women seeking PAC "You had sex, you had your excitement. Now you're crying, who will help you? We will just leave you to die."[119]

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

1. What steps are being taken to end the ongoing practice of detaining women in health care facilities, after giving birth, because of inability to pay medical bills? What efforts have been made to ensure that essential health care services, such as delivery services, are accessible to all women without cost?

2. What steps will the government take to prevent the ill-treatment of women seeking maternal health services, safe abortion and PAC? What concrete mechanism has the government established to ensure that women are able to report and seek redress for abuse and detention?

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

4. What measures is the government going to take to ensure women's access to safe and legal abortion services under the Constitution, How does it plan to address the lack of clarity surrounding the abortion law? Will the state expand the law to include the international human rights mechanisms' recommended exceptions for legal abortion, including in cases of sexual violence?

5. What concrete measures does the government propose to reduce maternal deaths due to unsafe abortion? What steps are being taken to ensure that health care facilities are adequately equipped to provide quality, hygienic maternal health care services and provide respectful, quality care?

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

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

2. It should put in place legislative, administrative, and other measures to prevent the abuse and neglect of women seeking maternal health services, safe abortion, PAC, and family planning services in health facilities. It should also ensure that ongoing measures to provide essential health care services, such as delivery services, at no cost to women are implemented in an effective manner.

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

4. It should address the lack of clarity surrounding the abortion law and increase the awareness of health care providers and women regarding when abortion is legal and provide sufficient institutional and monetary support to strengthen PAC services, including adopting a protocol regarding treatment of post-abortion patients. The government should also amend the current law to allow for abortion for victims of rape and other forms of sexual violence.

5. The government should allocate more resources to the health sector to increase the number of health facilities that are adequately equipped to provide quality and respectful care; ensure an adequate and consistent supply of contraceptives, including emergency contraception; develop comprehensive guidelines on the obligations of all health facilities to provide accurate and comprehensive family planning services; and establish a clear referral policy for facilities that cannot or choose not to provide certain family planning information or services.

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

Sincerely,

Evelyn Opondo
Regional Director for Africa
Global Legal Program

Onyema Afulukwe
Legal Adviser for Africa
Global Legal Program

[1] Committee against Torture (CAT Committee), *General Comment No. 2: Implementation of article 2 by States parties*, (39th Sess., 2007), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 376, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CAT Committee, *Gen. Comment No. 2*].
[2] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, art. 1, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) (*acceded by Kenya* Feb. 21, 1997).
[3] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No.16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (*acceded by Kenya* May 1, 1972); African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified by Kenya* Jan. 23, 1992).
[4] CONSTITUTION OF KENYA (2010), art. 29.
[5] CAT Committee, *Gen. Comment No. 2*, *supra* note 1, para. 4.
[6] *Id.* para. 2.
[7] *Id.* paras. 4 & 14.
[8] *Id.* para. 22.
[9] Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, para. 46, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan E. Méndez) [hereinafter Rep. of SRT (2013)].
[10] Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 3452 (XXX), annex, 30 U.N. GAOR Supp. (No. 34) at 91, art. 2, U.N. Doc. A/10034 (1975). The Declaration is referenced in the preamble of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
[11] CONSTITUTION OF KENYA (2010), art 29.
[12] CAT Committee, *Gen. Comment No. 2*, *supra* note 1, para. 10.
[13] Special Rapporteur on the question of torture, *Rep. of the Special Rapporteur on the question of Torture—Civil and Political Rights, including the Questions of Torture and Detention*, para. 35, U.N. Doc. E/CN.4/2006/6 (Dec. 23, 2005) (by Manfred Nowak) [hereinafter Rep. of SRT (2005)].
[14] CAT Committee, *Gen. Comment No. 2*, *supra* note 1, para. 11.
[15] *Id.* paras. 15 & 18.
[16] CAT Committee, *Concluding Observations*: *Kenya*, para. 15, U.N. Doc. CAT/C/KEN/CO/1 (2009).
[17] *Id.* para. 10.
[18] CENTER FOR REPRODUCTIVE RIGHTS, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 56-57, n. 374 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [hereinafter FAILURE TO DELIVER].
[19] *Id.* at 56-57; Focus Group Discussion, in Nairobi, Kenya (Mar. 1, 2012) (on file with the Center for Reproductive Rights).
[20] In a 2006 interview, one high-ranking doctor noted that the practice of detaining patients until they pay their bills is "widespread" and that every facility, including his own and the Kenyatta National Hospital, engages in the practice. *Id.* at 56, n. 374.
[21] *Id.* at 56-57.
[22] *Id.*
[23] KENYA NATIONAL COMMISSION ON HUMAN RIGHTS (KNHCR), REALISING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR A REALITY? A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA (2012) [hereinafter KNHCR, PUBLIC INQUIRY REP. (2012)].
[24] *Id.* at 133-134, 151.
[25] Focus Group Discussion, *supra* note 19.
[26] *Id.*
[27] *Id.*
[28] *Id.*

[29] *Id.*
[30] FAILURE TO DELIVER, *supra* note 18, at 57.
[31] *Id.*
[32] Focus group discussion participant, in Nairobi, Kenya (Mar. 1, 2012) (on file with the Center for Reproductive Rights).
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *See, i.e.* Jason Straziuso, *Kenya hospital imprisons new mothers with no money*, THE GRIO – NBC NEWS (Dec. 28, 2012, 11:24 AM), http://thegrio.com/2012/12/28/kenya-hospital-imprisons-new-mothers-with-no-money/; Gabe Joselow, *Women Detained at Kenyan Maternity Hospital Demand Justice*, VOICE OF AMERICA (Dec. 10, 2012), http://www.voanews.com/content/women-detained-at-maternity-hospital-in-kenya-demand-justice/1562030.html.
[37] Government of Kenya, *Consideration of reports submitted by States parties under article 19 of the Convention: 2nd periodic report of States parties due in 2012, submitted in response to the list of issues (CAT/C/KEN/Q/2) transmitted to the State party pursuant to the optional reporting procedure (A/62/44, paras. 23 and 24): Kenya*, para. 71, U.N. Doc. CAT/C/KEN/2 (2012).
[38] Petition filed by the Center to the High Court of Kenya, at 7 (Dec. 7, 2012) (on file with the Center for Reproductive Rights).
[39] Rep. of SRT (2013), *supra* note 9, para. 45 (*citing* CAT/C/CR/32/5, para. 7 (m); Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 228, para. 11, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *Gen. Comment No.* 28].
[40] CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011).
[41] CAT Committee, *Concluding Observations*: *Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006).
[42] Rep. of SRT (2005), *supra* note 13, para. 35.
[43] Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *Rep. of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment, Manfred Nowak*, paras. 68-70, U.N. Doc. A/HRC/10/44, (Jan. 14, 2009).
[44] *See generally*, FAILURE TO DELIVER, *supra* note 18; *see also* CENTER FOR REPRODUCTIVE RIGHTS, AT RISK: RIGHTS VIOLATIONS OF HIV-POSITIVE WOMEN IN KENYAN HEALTH FACILITIES (2008), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/At%20Risk.pdf.
[45] *See* FAILURE TO DELIVER, *supra* note 18, at 28-29, 33-34.
[46] *See id.*
[47] *Id.*
[48] *Id.* at 35.
[49] *Id.*
[50] *Id.* at 34 (*cited* Focus group discussion with unnamed participant, Kisumu, Apr. 5, 2007).
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.* at 28 (*cited* Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007).
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] KNHCR, PUBLIC INQUIRY REP. (2012), *supra* note 23, at 51.
[61] *Id.* at 70.
[62] CAT Committee, *Gen. Comment No. 2*, *supra* note 1, para. 4.
[63] *Id.* para. 2.
[64] *See* FAILURE TO DELIVER, *supra* note 18, at 66-76.
[65] *Id.* at 70.

[66] "The Nursing Council takes between three months and two years to resolve cases." *See id.* at 69.
[67] FAILURE TO DELIVER, *supra* note 18, at 72-73.
[68] CAT Committee, *Concluding Observations*: *Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006); *Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); Rep. of SRT (2013), *supra* note 9, paras. 45-46.
[69] *See* CAT Committee, *Concluding Observations*: *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); *see also*, CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011); Human Rights Committee, *Gen. Comment No. 28*, *supra* note 39, para. 11; Human Rights Committee, *Concluding Observations*: *Morocco*, para. 29, U.N. Doc. CCPR/CO/82/MAR (2004).
[70] CAT Committee, *Concluding Observations*: *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009); *see also* CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011).
[71] *See e.g.*, CAT Committee, *Concluding Observations*: *Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
[72] CONSTITUTION OF KENYA (2010), art. 26(4).
[73] Mercy Randa, *Sexual Abuse Cases on Children Up*, THE NATION (June 16, 2006).
[74] MICHELLE J. HINDEN ET AL., INTIMATE PARTNER VIOLENCE AMONG COUPLES IN 10 DHS COUNTRIES: PREDICTORS AND HEALTH OUTCOMES 63 (United States Agency for International Development, 2008), *available at* http://www.measuredhs.com/pubs/pdf/AS18/AS18.pdf.
[75] CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 42 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf [hereinafter IN HARM'S WAY] (*cited* Renson Mnyamwezi, *NGO decries rise in rape cases*, The Standard, April 23, 2009, at 9).
[76] Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION (Nov. 1, 2009), http://allafrica.com/stories/200911020402.html (last visited May 13, 2013).
[77] IN HARM'S WAY, *supra* note 75, at 71.
[78] *Id.* at 42.
[79] Katy Migiro, *One third of Kenyan girls subjected to sexual violence – survey*, TRUSTLAW (Nov. 28, 2012, 5:25 PM), http://www.trust.org/trustlaw/news/one-third-of-kenyan-girls-subjected-to-sexual-violence-survey.
[80] Lillian Onyango, *Fight against sexual violence in Kenya 'dimmed'*, DAILY NATION (Mar. 22, 2013, 8:40), http://www.nation.co.ke/News/-/1056/1727326/-/wq41n6z/-/index.html.
[81] IN HARM'S WAY, *supra* note 75, at 43.
[82] *Id.*
[83] *Id.* at 45.
[84] *See* CAT Committee, *Concluding Observations: Peru*, para. 23, U.N. Doc. CAT/C/PER/CO/4 (2006).
[85] KNHCR, PUBLIC INQUIRY REP. (2012), *supra* note 23, at 47.
[86] *Id.* at 66-67.
[87] CAT Committee, *Concluding Observations: Ireland*, para. 26, U.N. Doc. CAT/C/IRL/CO/1 (2011).
[88] *Id.*
[89] *Id.*
[90] *See* IN HARM'S WAY, *supra* note 75, at 57.
[91] PENAL CODE (2009), ch. 63, art. 240 (Kenya) (Which provides that: "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."
[92] MINISTRY OF HEALTH AND SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 21 (2nd ed., 2009), *available at* http://www.svri.org/nationalguidelines.pdf.
[93] IN HARM'S WAY, *supra* note 75, at 57.
[94] Guttmacher Institute, *Fact Sheet: Abortion and Unintended Pregnancy in Kenya* (May 2012), *available at* http://www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf.
[95] *Id.*
[96] *Id.*; *see also* Bernard Muthaka, *Penal code slowing down constitutional abortion care services*, STANDARD DIGITAL (Dec. 9, 2012, 00:00 GMT), http://www.standardmedia.co.ke/?articleID=2000072431&story_title=Kenya-Penal-code-slowing-down-constitutional-abortion-care-services.
[97] Guttmacher Institute, *supra* note 94.
[98] IN HARM'S WAY, *supra* note 75.

[99] WORLD HEALTH ORGANIZATION, MATERNAL MORTALITY IN 2005: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, AND THE WORLD BANK 25 (2007), *available at* http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf (According to this publication, Kenya has 7,700 maternal deaths per year and according to the Ministry of Health and the Kenya Demographic and Health Survey 1998, 35% of pregnancy related mortality is attributable to unsafe abortion).
[100] *See* IN HARM'S WAY, *supra* note 75, at 128-142.
[101] CAT Committee, *Concluding Observations: Paraguay*, para. 22, U.N. Doc. CAT/C/PRY/CO/4-6 (2011).
[102] CAT Committee, *Concluding Observations: Chile*, para. 7(m), U.N. Doc. CAT/C/CR/32/5 (2004).
[103] *Id*.
[104] *Id*.
[105] CAT Committee, *Concluding Observations: Peru*, para. 15(d), U.N. Doc. CAT/C/PER/CO/6, (2012).
[106] MINISTRY OF HEALTH (TANZ.), POST ABORTION CARE TRAINER'S MANUAL, at 1, 30 [hereinafter POST ABORTION CARE TRAINER'S MANUAL] (*citing* MINISTRY OF HEALTH (KENYA), REPRODUCTIVE HEALTH GUIDELINES AN STANDARDS FOR SERVICE PROVIDERS (1997)).
[107] *See* KNHCR, PUBLIC INQUIRY REP. (2012), *supra* note 23, at 49-59(2012); IN HARM'S WAY, *supra* note 75, at 76.
[108] POST ABORTION CARE TRAINER'S MANUAL, *supra* note 106, at 1-24.
[109] The training manual provides that "[c]omprehensive PAC is a life-saving procedure that should be available to all women and provision of comprehensive post-abortion care does not lead to punishment or withdrawal of registration of the service provider." It does not, however, address the issue of women fearing to seek PAC for fear of prosecution. *Id*.
[110] IN HARM'S WAY, *supra* note 75, at 76-77 (*cited* Interview with Grace, Dandora, July 14, 2009).
[111] *Id.* at 78 (*cited* Interview with Nurse/Administrators, Maternity Hospital, Nairobi, June 20, 2009).
[112] *Id.*
[113] *Id.* at 77.
[114] *Id.* at 90.
[115] KNHCR, PUBLIC INQUIRY REP. (2012), *supra* note 23, at 48.
[116] IN HARM'S WAY, *supra* note 75, at 89 (*cited* Interview with Dr. Aggrey Otieno Akula, Medical Superintendent, Kisumu East District Hospital, Kisumu, July 27, 2009).
[117] *Id.* at 92 (Focus Group discussion with unnamed participant, Mombasa, Aug. 4, 2009).
[118] *Id*.
[119] *Id*.