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RIGHTS

July 13, 2007

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on Kenya Scheduled for Review during the 39th Session of the CEDAW Committee

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by the government of Kenya, which is scheduled to be reviewed by this Committee during its 39th Session. The Center for Reproductive Rights (CRR), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW or "the Convention"). This letter highlights several areas of concern related to the status of women's reproductive health and rights in Kenya.

Reproductive rights are fundamental to women's health and social equality and are an explicit part of the Committee's mandate under CEDAW; a state's commitment to respect, protect, and fulfill these rights should receive serious attention. Despite explicit protections in the Convention, the reproductive rights of women and girls in Kenya continue to be neglected and, at times, blatantly violated. The development and implementation of laws, policies, and programs that cater specifically to women's health needs and that eliminate discrimination are necessary to ensure and advance women's fundamental human rights.

We wish to bring to the Committee's attention two areas of particular concern: women's lack of access to reproductive health care and discrimination against women when they seek or receive reproductive health services. These problems reflect shortfalls in the government's implementation of CEDAW and directly affect the reproductive health and lives of women in Kenya. This letter is accompanied by a fact-finding report on these issues, *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, produced by CRR and the Federation of Women Lawyers–Kenya (FIDA Kenya).

I. RIGHT TO REPRODUCTIVE HEALTH CARE AND INFORMATION (ARTICLES 10, 12, 14(2)(b), AND 16(1)(e))

Ratification of the Convention commits states to "ensure ... [a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning" [Article 10(h)]; "to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning [and] ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period" [Article 12]; to ensure to rural women "access to adequate health care facilities, including information, counseling, and services in family planning" [Article 14(2)(b)]; and to ensure to women the "rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" [Article 16(1)(e)].

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A. MATERNAL MORTALITY AND MORBIDITY

Maternal death is defined as any death that occurs during pregnancy, childbirth, or within two months after birth or termination of a pregnancy.[1] Maternal mortality levels and trends serve as indicators of the health status of women and may point to violations of civil and political rights, as well as economic, social, and cultural rights. High rates of maternal mortality could be linked to violations of women's fundamental rights to life, freedom from inhuman and degrading treatment, health, education, information, and freedom from discrimination.

The Committee has framed the issue of maternal mortality as a violation of women's right to health and right to life.[2] The Committee has noted that "[m]any women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services." The Committee has further noted that "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services."[3]

The recognition of maternal mortality as a human rights issue has been underscored by the United Nations Special Rapporteur on the Right to Health, who has noted:

> Maternal mortality is not just a health or humanitarian issue – it is a human rights issue. Avoidable maternal mortality violates women's rights to life, health, equality and non-discrimination. The human rights community should take up maternal mortality just as vigorously as it does extrajudicial executions, disappearances, arbitrary detention, and prisoners of conscience.[4]

Reduction of maternal mortality is also one of the eight Millennium Development Goals (MDGs) agreed to by Kenya.[5]

In its combined fifth and sixth periodic report, the Kenyan government states that it "plans to improve maternal health services through promotion of safe motherhood,"[6] but does not give specific details on how it is going to address pregnancy and childbirth-related complications, which are one of the leading causes of morbidity and mortality for Kenyan women.[7]

Women in Kenya have a 1-in-25 lifetime risk of dying from a pregnancy-related cause. According to the 2003 Kenya Demographic and Health Survey (2003 KDHS), the maternal mortality ratio was 414 maternal deaths per 100,000 live births for the ten-year period prior to the 2003 survey.[8] Although this represents a decline from the rate of 590 calculated in the 1998 Kenya Demographic and Health Survey, the survey acknowledged "it is impossible to say with confidence that maternal mortality has declined" over the last five years.[9] Currently, maternal deaths account for 15% of all deaths to women aged 15 to 49.[10] As high as these numbers are, they do not capture the number of women who survive pregnancy but suffer lasting pregnancy-related health problems and disabilities such as obstetric fistula (where a hole develops either between the rectum or bladder and the vagina).

Although the Ministry of Health and National Coordinating Agency for Population and Development identify maternal health as a priority issue, the 2004 Kenya Service Provision Assessment Survey [2004 KSPAS] demonstrates that very few health care facilities in the country are fully equipped and prepared to provide comprehensive quality maternal health care.[11] Of the facilities in the survey that provided delivery services, only 40% had all the necessary items for infection control; only 36% had all essential supplies for delivery; only 26% had the necessary medicines and supplies for handling common complications; and only 13% were equipped to handle serious complications.[12]

Kenya is obligated under CEDAW to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period."[13] For the government to comply with this obligation, people must be able to trust the public health care system enough to use it, rather than forgoing care or seeking it from more informal sources. A program of reducing maternal mortality by encouraging women to seek skilled delivery assistance is undermined if women feel that they would be safer avoiding health care facilities and, as one Kenyan woman described it, "giving birth on the roadside."[14]

B. ABORTION

Unsafe abortion is one of the most easily preventable causes of maternal mortality and morbidity. Where death does not result from unsafe abortion, women may experience long-term disabilities, such as uterine perforation, chronic pelvic pain, or infertility. However, despite Kenya's stated commitment to reducing maternal mortality, its abortion law is among the most restrictive in the world, and, according to the Kenya Medical Association and the Kenya Obstetric and Gynecological Society, unsafe abortion causes between 30 and 40% of the maternal deaths in Kenya.[15] As in most African nations, Kenya's abortion law has its origins in the laws of colonial predecessors—nations that have since reformed their own laws. The current Kenyan law does not provide an exception in cases of rape and incest, in spite of the high rates of sexual violence and limited access to contraceptives [see below].[16]

In addressing abortion, the government's report recognizes that unsafe abortions are one of the leading causes of the high maternal mortality rates in Kenya.[17] In spite of this, abortion remains illegal unless the mother's life is at risk.[18] In fact, as the government notes, abortion is the only criminal offense to have been incorporated into the proposed new Constitution.[19] By forcing women to undergo unsafe clandestine abortions, Kenya's restrictive abortion law itself threatens women's rights to life and health. "Three out of four [post-abortion care] patients arrive in critical condition—gasping," explained the nurse-administrator of a private clinic in a low-income area. "One woman's infection was so bad that we could smell her while she was outside approaching the building, and flies were following her. She had had an abortion about a week ago, and everything was toxic. In most cases, it's not easy to keep fertility."

The CEDAW Committee has recognized the danger in forcing women to undergo illegal, unsafe abortions, stating that states should "ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control."[20] The committees that oversee compliance with the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of the Child have similarly characterized high rates of maternal mortality caused by abortion as violations of the rights to health and life, and have explicitly asked states to review legislation criminalizing abortions.[21] In the case of Kenya, both the Human Rights Committee and the Children's Rights Committee have specifically expressed concern over Kenya's restrictive abortion law and its link to maternal mortality.[22]

Restrictive abortion laws also constitute discrimination against women, as defined in article 1 of the Convention.[23] Denying access to a medical procedure that only women need exposes women to health risks not experienced by men, as only women incur the direct physical and emotional consequences of an unwanted or dangerous pregnancy. Such laws also discriminate against young and low-income women who are less likely to have the resources to access safe abortion in Kenya or abroad.[24] Poorer women are forced to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications. Girls are also less likely to be able to access and afford safe abortion services and may feel additional pressure to terminate a pregnancy because of the social stigma of pregnancy and the difficulties of continuing their education. A recent medical study on abortion found that factors contributing to unsafe abortion included educational needs, failed contraception, stigma attached to childbearing outside of marriage, lack of support from one's spouse and/or family, religion, and lack of family planning services for adolescents.[25]

The following statistics demonstrate unsafe abortion's terrible toll on Kenyan women's lives and the tremendous pressure it places on an already resource-strapped health care system. In early May 2004, the government, along with the Kenyan Medical Association and two NGOs, released the "National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya." According to the report, approximately 300,000 spontaneous and induced abortions occur each year, putting the national incidence of abortion per 1,000 women aged 15-49 at 44.7%.[26] This same report estimated that 20,000 women are treated in public hospitals annually with abortion-related complications.[27] A study on abortion in a Kenyan provincial hospital found that abortion accounted for 43% of all women admitted with acute gynecological conditions,[28] and that an average of 91 bed-hours are necessary to treat abortion complications (compared to 39 bed-hours for other acute gynecological complications).[29]

C. ACCESS TO COMPREHENSIVE FAMILY PLANNING SERVICES AND INFORMATION

Access to contraceptives and family planning is central to protecting women and girls' rights to life and health. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate health care, or they may seek out unsafe illegal abortions that can result in complications or death. Moreover, lack of access to contraceptives affects women's right to control their fertility, the right to decide whether to have children and the number and the spacing of children, and the right to self-protection against sexually transmissible infections (STIs) including HIV/AIDS.

The Convention explicitly recognizes the rights of women to access family planning services. States have a duty under CEDAW "to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning."[30] The Convention also affirms the right of women "to decide freely and responsibly on the number and spacing of their children," and declares that states must ensure that women "have access to the information, education and means to enable them to exercise these rights."[31]

Donor support for family planning facilities in Kenya has been dwindling, the government has not been allocating adequate funding for contraceptives, and there have been logistical problems with contraceptive distribution.[32] In recent interviews conducted by FIDA Kenya and CRR, women and health care providers also reported numerous obstacles to obtaining contraceptives, including formal or informal user fees even when the contraceptive method was supposed to be provided for free by the government; unavailability of a preferred contraceptive method; incorrect and biased family planning information; and absence of supplies necessary to insert certain methods.[33]

All these factors create barriers to contraceptive use, which in turn can result in unwanted pregnancies and unsafe abortions.[34] One woman, who had experienced problems with hormonal contraceptives, described her experiences of trying to get an intra-uterine device (IUD) to FIDA Kenya and CRR. Because the cost was at least 400% more in private facilities, the woman decided to go to a local public hospital to have the IUD inserted. The first two times that she went to the public hospital, IUDs were out of stock and she was told to try again at a later date. On her third visit, the hospital had the IUD but no gloves, so the health care provider could not insert it. During the two-month period when she was using natural family planning while trying to obtain an IUD, the woman became pregnant and miscarried.

The 2003 KDHS reveals that nearly 20% of births are unwanted and another 25% are mistimed.[35] Furthermore, the contraceptive prevalence rate among currently married women is only 39%.[36] According to the survey, the steady increase of contraceptive use among married women since the 1980s slowed considerably after 1998.[37] The 2003 KDHS also demonstrates an unmet need for contraception among girls in Kenya. While only surveying currently married women, the survey found the unmet

family planning need among married young women, aged 15-19, was 27.8%.[38] In addition, the 2003 KDHS found that only 12% of women and 10% of men aged 15-19 used a condom during their first sexual encounter.[39]

Family planning information and services must go hand-in-hand to be effective. Failure to provide information on reproductive health threatens the rights to life, health, autonomy in decision-making, and all other reproductive rights of women and girls. Since lack of access to reproductive health information is associated with high rates of maternal mortality, high rates of abortion, adolescent pregnancies, and HIV/AIDS, it is critical that the government of Kenya place greater emphasis on the provision of accurate information to women and girls in a way that is both comprehensive and accessible. It is vital that information reach all women irrespective of age and education.

Access to reproductive health information and services can be particularly critical for adolescent girls. Children born to adolescent mothers are predisposed to higher risks of illness or death, and adolescent mothers are more likely to experience life-threatening complications during and after pregnancy.[40] Moreover, early entry into reproduction often denies young women the opportunity to pursue basic education and is detrimental to their prospects for good careers, which often lowers their status in society.[41] In spite of the high risks of becoming sexually active at an early age, the 2003 KDHS documents that 14.5% of girls and 30.9% of boys had their first sexual encounter by the time they reached age 15.[42]

The plan of action for Kenya's Adolescent Reproductive Health and Development Policy recognizes that "[i]nformation and education on sexual and reproductive health is important for adolescents" and that "[t]hey need accurate, appropriate information to...make sound choices, enjoy healthy and positive lifestyles, and avoid undesired consequences like unwanted pregnancies and sexually transmitted infections."[43] In practice, however, young people in Kenya often have trouble getting contraceptives or information about safe sex, which can lead to high rates of STIs including HIV, unplanned pregnancy, unsafe abortion, and maternal deaths. The early age of sexual debut in Kenya, high rates of maternal death, and ignorance about safe sex and sexuality raise serious questions about the effective implementation of this and similarly designed programs.

In 2007, the Children's Rights Committee expressed concern over Kenya's high number of teenage pregnancies, the criminalization of abortion in cases of rape and incest, the lack of accessible sex education and reproductive health services, and the difficulties pregnant girls face in continuing their education.[44] In its Concluding Observations, the Committee recommended that the Kenyan government give young people access to confidential HIV testing and contraceptives; provide adolescents with reproductive health counseling services and make sure they know these services are available; step up HIV prevention efforts by providing youth with comprehensive information about safe sex; train health workers and teachers on how to teach about these subjects; and provide support to pregnant teenagers and help them find ways to continue their education.[45]

D. HIV/AIDS

Accurate information on prevention and treatment of STIs is a key component of sexual and reproductive health. The failure to inform women about prevention and treatment of STIs, including HIV/AIDS, is an infringement of their rights to life and health. The CEDAW Committee has noted that "[t]he issues of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health," and has urged "States parties [to] ensure, without prejudice and discrimination, the right to sexual health information, education and services for all women and girls."[46] Yet, in Kenya, knowledge of HIV/AIDS risk factors and prevention measures is erratic and comprehension of transmission and prevention routes is especially dismal. For instance, more than half of all young women

aged 15-19 believe they have no chance of getting HIV and 43.5% of men of the same age share that belief.[47] Approximately 70% of Kenyans know that HIV can be transmitted by breastfeeding, but only one-third of women and 38% of men know that taking certain drugs during pregnancy can reduce the risk of mother-to-child transmission.[48]

The general lack of information around HIV transmission has a disproportionate, adverse effect on women. As the government's report notes, HIV/AIDS affects more women than men in Kenya.[49] This is particularly true among younger women. Three percent of women aged 15-19 are HIV positive, while less than half of one percent of men aged 15-19 test positive.[50] HIV prevalence among women 20-24 is over three times that of men in the same age group (9% and 2% respectively).[51] Recent focus group discussions conducted by FIDA Kenya and CRR with HIV positive women confirm that health care providers often fail to provide women with the necessary information to prevent or minimize HIV transmission from mother to child. One woman described her experience:

> [W]hen I was pregnant with my last-born child in 1997, at the time they tested me for HIV they did not inform [me] of my status. When the child was nine years [of age] he became very ill and I was advised to take him for testing and he tested positive. I asked why this happened and they told me through breastfeeding.

Many women reported that they breastfed their children, regardless of whether they knew their HIV status, because they were unaware of the risk of, or ways to minimize, mother-to-child transmission, and they did not have access to this information.[52]

Efforts aimed at preventing the spread of HIV in Kenya usually center on what is known as the ABC approach (abstain until marriage, be faithful within marriage, use condoms), but a recent study indicates that ABC programs are not clearly communicating vital information that adolescents need to protect themselves from HIV.[53] This 2004 Kenyan study showed that while in-school youth were generally aware of HIV, many did not have a clear understanding of what the ABC terms meant.[54] Especially worrisome was the finding that two thirds of youth respondents felt that condoms were bad and that they may be "ineffective."[55] (This situation was not improved when Lucy Kibaki, Kenya's first lady and chair of the Organization of the 40 African First Ladies against HIV/AIDS, publicly stated, "Those who are still in school have no business having access to condoms."[56]) Furthermore, an emphasis on abstinence until marriage is both flawed and dangerous when girls are often forced into non-consensual sexual relations and when marriage itself can actually be a risk factor for contracting HIV.

The high rate of early marriages in Kenya also contributes to the vulnerability of adolescent girls to HIV infection. Approximately 25% of women aged 20-24 in 2003 were married by the time they turned 18, and more than half of those women entered into polygamous marriages.[57] A 2001 study among sexually active girls aged 15-19 in Kisumu, Kenya found that the HIV infection rate was more than 10% higher for married than for unmarried girls (married 33%, unmarried 22%).[58] The study also found that early marriage increases the frequency of sex, decreases condom use, and makes it harder for girls to abstain from sex.[59] Additionally, husbands of married girls were three times more likely to be HIV-positive than sexual partners of unmarried girls.[60]

In spite of the multiple risks early marriage can pose, Kenya's marriage laws do not adequately protect young women. Although the Children Act indirectly defines the minimum age for marriage as 18,[61] the Marriage Act[62] and the Hindu Marriage and Divorce Act[63] both specify that the minimum age of marriage is 16 for a girl and 18 for a boy. Customary and Islamic laws generally allow adolescents who have reached puberty to marry, regardless of their age.[64] In recognition of both the discriminatory nature of different marriage ages for boys and girls and the risks of early marriage, the Children's Rights

Committee has called upon Kenya to harmonize its marriage laws and set 18 as the minimum legal age of marriage for both boys and girls.[65]

II. RIGHT TO BE FREE FROM DISCRIMINATION, INCLUDING GENDER-BASED VIOLENCE (ARTICLES 1, 2, 12, 14, AND 16)

The Convention defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the *effect or purpose* of impairing or nullifying the recognition, enjoyment or exercise by women ... of human rights and fundamental freedoms."[66] Accordingly, the Committee has determined that an act "that is directed against a woman because she is a woman or that affects women disproportionately" constitutes gender-based discrimination.[67]

States are obligated under CEDAW to take steps to eliminate sex-based discrimination by both public and private actors.[68] This requirement of non-discrimination permeates all of Kenya's duties under CEDAW, including the obligation "to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services" [Article 12(1)]; the obligation "to eliminate discrimination against women in rural areas in order to ensure ... access to adequate health care facilities" [Article 14(2)]; and the obligation "to eliminate discrimination against women in all matters related to marriage and family relations [and to] ensure, on a basis of equality of men and women ... [t]he same rights to decide freely and responsibly on the number and spacing of their children" [Article 16(1)(e)]. In addition, the CEDAW Committee has determined that states have an obligation under the Convention "to eliminate all forms of violence against women," because discrimination against women includes gender-based violence.[69] Women seeking health care services encounter discrimination based on their income, age, gender, and HIV status.

A. DISCRIMINATION IN ACCESS TO HEALTH CARE

Health care costs—which can include the cost of the health good or service itself, fees for transportation, food, supplies or drugs that must be purchased and brought to the facility, and informal board charges—can prevent or delay women from accessing services, and can also impose additional health risks and hardship. User fees, in general, tend to hit women harder than men. The Kenyan government notes that poverty affects women more than men and female-headed households are worse off than other households.[70] Yet, women must frequently finance their own reproductive health care—a cost that men do not incur.

Informal and formal health care fees disproportionately affect low-income, rural, and less-educated women, who, according to the 2003 KDHS, are least likely to receive delivery assistance from medical professionals.[71] In its 2003 Concluding Observations, the Committee urged Kenya "to pay special attention to the needs of rural women, ensuring that they ... have full access to ... health services."[72] However, as the government's report indicates, the cost of medical care proves to be a significant barrier to rural women's access to health care.[73] The women that FIDA Kenya and CRR interviewed were acutely aware of the fact that money usually buys better treatment, noting differences both between the quality of care in public hospitals versus more expensive private facilities and in the discrimination against poor people seeking services at public facilities. One woman who delivered at a public hospital witnessed women who were unable to pay their bill being kicked out of their beds and forced to sleep on the floor so that the beds could be given to "people with money."[74] Although Kenya has implemented a general waiver in public hospitals for people who cannot meet their medical costs, the process is often burdensome and health care workers are often reluctant to inform patients about the waivers because the facility providing the waiver has to absorb the costs.[75]

Recent interviews with health care users and providers conducted by FIDA Kenya and CRR confirmed that many women fail to seek medical care because of the cost, while other women are denied entrance to health facilities because they are unable to afford the requisite deposit.[76] At Pumwani Maternity Hospital (PMH) in Nairobi, whose patients are among the poorest and the youngest women in Kenya,[77] the amount of the "deposit" is the full cost of the delivery service. One newspaper article recounts the story of a woman who died in the operating theatre after being denied delivery services at PMH because her husband could not raise the Kshs. 1200 ($17 US), which was the admission fee at the time. "She writhed in pain as other patients pleaded for her in vain. The nurse in charge refused to admit or refer her to doctors."[78] Patients who cannot pay the entire cost of medical care upfront may also find that they are denied full services even if they are admitted to a facility. A casual worker in a district hospital noted that medical providers would sometimes withhold treatment until full payment is made, saying that a woman "will be ... asked what will be used to tie the baby's umbilical cord. She is told to tell her husband to look for the balance. The cord clamp is just there [but] they will not use it until you bring the cash."[79]

Interviews with health care users and providers also document that both public and private health facilities have an ongoing practice of detaining patients who are unable to pay their medical bills.[80] One woman, whose baby died during delivery, describes her detention for her inability to pay the delivery fee: "My baby died. I don't know what killed her but I've to pay the bill first. ... At night I stay awake [and] hear babies suckling or crying. Then milk flows from my breasts ... I wish mine was alive."[81] Such detention policies violate many of the patient's fundamental rights, including the right to dignity and the right to be free from discrimination. The practice of detaining indigent patients has a disparate adverse effect on women, due to the greater number of women that are affected through pregnancy and childbirth. This disparity is heightened by the amplified vulnerability of women who are pregnant or have recently given birth, as recognized by the special protections granted to mothers during and for a reasonable period before and after childbirth under international human rights law.[82]

Kenya is obligated under CEDAW to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services when necessary."[83] In its 2007 Concluding Observations, the Children's Rights Committee, which oversees compliance with the Convention on the Rights of Children, recommended that the Kenyan government give all pregnant women health and social services free of charge.[84]

B. Abuse And Neglect When Seeking Reproductive Health Services

As the 2003 KDHS noted, "Proper medical attention under hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness either to the mother, baby, or both."[85] Furthermore, the government recognizes in its Maternal Care Standards that "good quality care provides a woman with dignity during childbirth."[86] However, the results of the 2004 KSPAS, 2003 KDHS, and the interviews and focus groups conducted for a new FIDA Kenya/CRR report on women's experiences with health care facilities in Kenya, revealed an alarming degree of rights violations occurring in medical facilities.[87]

Women who delivered their children in medical facilities described egregiously substandard medical services and negligent and abusive treatment at the hands of health care providers.[88] They recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear. One woman was told by a staff member to continue suffering because she was responsible for her pregnancy. During the night, when her pain became so intense that she was forced to crawl to the nurses for assistance, the nurses mocked her and asked if she "was exercising."[89] Numerous women also reported rights violations occurring around the suturing that is often necessary after childbirth. They described having to endure long, uncomfortable waits on a hard,

wooden bench; unreasonably painful and poorly performed stitching; refusal to provide anesthesia; and verbal abuse from providers before, during, and after the process.

This ill treatment was exhibited by providers across the spectrum, including doctors, midwives, nurses, and other staff in both public and private facilities—although the problems seem particularly prevalent in government hospitals, especially at Pumwani Maternity Hospital (PMH) in Nairobi. PMH, East Africa's busiest maternity hospital, has long been plagued by reports of abuse, neglect, and corruption, including accounts of unusually high maternal and infant mortality rates, stolen babies, and missing bodies of dead mothers.[90] These problems have lasted for decades and indicate a systemic pattern of serious human rights violations and government failure to address the problems in an effective and transparent manner. While a number of task forces have been formed over the past decade to investigate reports of abuse and neglect, there has been no public process of accountability and redress.[91]

Gender-based violence, such as verbal and physical abuse of women seeking reproductive health care services, infringes on women's fundamental rights to life, health and non-discrimination. The CEDAW Committee has defined gender-based violence as including "acts that inflict physical, mental or sexual harm or suffering [or] threats of such acts," and has noted that such acts are considered discrimination within the meaning of article 1 of the Convention.[92] Furthermore, the International Covenant on Economic, Social and Cultural Rights recognizes that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth."[93] The Kenyan government is obligated under its international human rights commitments to take measures to prevent and remedy the rights violations suffered by women during this time of great vulnerability.

C. DISCRIMINATION AGAINST HIV-POSITIVE WOMEN

In recent interviews with health care users, HIV positive women reported abuse and discrimination when seeking health services, a failure on the part of medical practitioners to minimize HIV transmission, either from mother to child or from patient to patient, and violations of their right to privacy and confidentiality.

Several HIV positive women reported abuse and neglect when seeking antenatal and delivery services as a result of their HIV status. One woman noted that "the nurses reprimanded me and harshly asked me why I had conceived [when] I knew of my status. I felt very bad."[94] Another woman noted that her HIV positive daughter was just left on the delivery bed, without being stitched or told where her child was. As one woman said, "you are not treated well especially if you are HIV positive. ... [W]e are left helpless."[95]

Interviews further confirmed that medical providers do not take adequate steps to minimize transmission of HIV during delivery. One woman noted that, while women who are HIV positive should be assisted in delivery, in practice, HIV positive women are discriminated against in delivery and do not receive the necessary care to minimize mother-to-child transmission. She explained that "if they check the card and see you are HIV you will be in labour for long and the blood will mix. The obstetrics services to ensure no transmission is not followed and there is that don't care attitude."[96] Another woman attributes contracting HIV to the care she received during delivery because the nurse failed to clean the scissors that she had used on another patient giving birth. In addition, many women assert that they did not receive adequate counseling about the virus and mother-to-child transmission, and when they tried to learn more, their questions were dismissed. One woman described her "counseling" experience: "you are told you are positive [and] you can't ask any question or even why you are being given a certain drug. You will be answered that 'if you know so well ... why didn't you treat yourself, why did you come here.'"[97]

Women also consistently reported that they were tested for HIV without their knowledge or consent, and were never informed of their HIV status following the unauthorized testing. One woman, who was unaware that she had been tested, learned that she was HIV positive when she heard the nurses speaking

loudly about her status in the halls of the hospital ward. A woman who works with a clinic that refers HIV positive youth for medical care at a government hospital reported that nurses failed to respect the patient's confidentiality, and would ask loudly in the presence of other patients whether the patient was receiving treatment for HIV.

In its 2003 Concluding Observations, the CEDAW Committee urged the Kenyan government to take "strong preventative measures and to ensure that women and girls infected with HIV/AIDS are not discriminated against and are given appropriate assistance."[98] The experiences of the women interviewed demonstrate that such discrimination remains rampant, and this discrimination creates a significant barrier to the access of appropriate health care.

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

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

2) What measures has Kenya taken to liberalize its abortion law and safeguard the lives of women and girls from unsafe abortion, one of the primary causes of maternal mortality? What governmental efforts exist to ensure post-abortion care for complications as well as for reproductive health counseling? What measures are being taken to ensure that women who develop complications are not doubly victimized by both the health care and the criminal justice systems?

3) How does the government propose to improve access to contraceptives, ensuring that women are informed of, and have access to, family planning options? Is the government taking steps to ensure that contraceptives are equally and consistently distributed to non-public institutions?

4) What measures are being taken to ensure that women and girls receive accurate and comprehensive information on prevention and treatment of HIV? Are integrated service programs being developed to ensure access to comprehensive reproductive health services which address both the need for contraception and STI and HIV prevention?

5) What steps are being taken to make access to contraceptives, emergency contraception and post-exposure prophylaxis a reality? How does the government plan to ensure that all health facilities are providing survivors of sexual violence with access to emergency contraception?

6) What efforts are being made to ensure that essential health care services, such as delivery services, are accessible to all women without cost? How does the government plan to ensure, once user fees are eliminated, that public hospitals are in fact providing these services free of cost? What steps are being taken to ensure that women are neither denied delivery services nor detained in facilities after giving birth for their inability to pay?

7) Access to health care services is contingent on adequate health care staffing in all health facilities including those in rural areas. What measure has the government taken to ensure the recruitment, training, and retention of health workers? How does the government propose to improve training of health care providers about patients' rights and to reduce the abuse and neglect of patients by medical staff? What is being done to improve working conditions for hospital and clinical staff to minimize low worker morale?

8) What steps are being taken to protect women and girls from gender-based violence and abuse in health care facilities? How does the government propose to ensure that women are able to report and seek redress for such abuses?

There remains a significant gap between the provisions of CEDAW and the reality of women's reproductive health and lives in Kenya. We appreciate the active interest that the Committee has taken in women's reproductive health and rights and the strong Concluding Observations and General Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure their realization.

We hope that this information is useful during the Committee's review of the Kenyan government's compliance with the Convention. A significant amount of the information in this letter is based on a recent report published jointly by FIDA Kenya and CRR, entitled *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*, which is being submitted with this letter. If you have any questions, or would like further information, pleased do not hesitate to contact the undersigned.

Sincerely,

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Legal Adviser, Africa Program
Center for Reproductive Rights

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[1] CENTRAL BUREAU OF STATISTICS [KENYA], 2003 KENYA DEMOGRAPHIC AND HEALTH SURVEY 236 (2004) [hereinafter KDHS 2003].

[2] *See, e.g.*, Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (Jan. 7, 1999); CEDAW Committee, *Concluding Observations: Colombia*, para. 393, U.N, Doc A/54/38 (Apr. 2, 1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 337, U.N. Doc A/53/38 (May 14, 1998).

[3] Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Women and health*, para. 27 (Feb. 5, 1999) [hereinafter CEDAW General Recommendation 24].

[4] The Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, delivered to the General Assembly* (Oct. 19, 2006), *available at* www2.essex.ac.uk/human_rights_centre/rth/docs/oral%20remarks%20of%20Paul%20Hunt%20GA%202006.doc.

[5] UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 12-13 (2006), *available at* http://unstats.un.org/unsd/mdg/Resources/Static/Products/Progress2006/MDGReport2006.pdf. The reduction of maternal mortality has also been a key goal at several recent international conferences. *See, e.g.*, Fourth World Conference on Women, Sept. 4-15, 1995, *Beijing Declaration and the Platform for Action*, para. 107(i), U.N. Doc. A/CONF.177/20 (Oct. 17, 1995), *available at* http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en; International Conference on Population and Development, Sept. 5-13, 1994, *Programme of Action of the International Conference on Population and Development*, para. 8.21, U.N. Doc. A/CONF.171/13/Rev.1 (Oct. 18, 1994), *available at* www.un.org/popin/icpd/conference/offeng/poa.html.

[6] Government of Kenya, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined fifth and sixth periodic reports of States parties: Kenya*, para. 122, U.N. Doc. CEDAW/C/Ken/6 (Oct. 16, 2006) [hereinafter Kenya Government Report].

[7] NAT'L COORDINATING AGENCY FOR POPULATION AND DEV. [KENYA], MINISTRY OF HEALTH [KENYA], AND CENTRAL BUREAU OF STATISTICS [KENYA], 2004 KENYA SERVICE PROVISION ASSESSMENT SURVEY 111 (Nov. 2005) [hereinafter KSPAS 2004].

[8] KDHS 2003, *supra* note 1, at 237.

[9] *Id.*

[10] *Id.*

[11] KSPAS 2004, *supra* note 7, at 128-140.

[12] *Id.* at 135. Items for infection control include hand washing supplies, clean or sterile gloves, disinfecting solution and a sharps box. *Id.* at 131.

[13] Convention on the Elimination of All Forms of Discrimination against Women art. 12(2), adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (entered into force Sept. 3, 1981) [hereinafter CEDAW].
[14] Interview with health care user, Nairobi, Apr. 11, 2007.
[15] *Kenyan Medics Call for Legalization of Abortion to Reduce Maternal Deaths*, BBC Monitoring International Reports, Jan. 29, 2004.
[16] The Penal Code § 240, Cap. 63 of the Laws of Kenya, (Revised ed. 1985). The Ministry of Health, in its guidelines on the care of survivors of rape and sexual violence, has indicated that abortion may be available when pregnancy is a result of rape. However, the legal basis for this policy is not explicit in existing legislation. DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH [KENYA], NATIONAL GUIDELINES: MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE 9 (2004).
[17] Kenya Government Report, *supra* note 6, at para. 128.
[18] *Id.* at para. 179.
[19] *Id.* at para. 129.
[20] Committee on the Elimination of Discrimination against Women, General Recommendation 19: Violence against women, para. 24(m), U.N. Doc A/47/38 (Jan. 29, 1992) [hereinafter CEDAW General Recommendation No. 19].
[21] *See, e.g.*, Committee on the Rights of the Child, *Concluding Observations: Chad*, para. 30, U.N. Doc. CRC/C/15/Add.107 (Aug. 24, 1999); Committee on the Rights of the Child, *Concluding Observations: Colombia*, para. 48, U.N. Doc. CRC/C/15/Add.137 (Oct. 16, 2000); Committee on the Rights of the Child, *Concluding Observations: Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (July 9, 2001); Committee on the Rights of the Child, *Concluding Observations: Nicaragua*, para. 35, U.N. Doc. CRC/C/15/Add.108 (Aug. 24, 1999); Committee on the Rights of the Child, *Concluding Observations: Nicaragua*, para. 19, U.N. Doc. CRC/C/15/Add.36 (June 20, 1995); Committee on Economic, Social and Cultural Rights, *Concluding Observations: Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (Dec. 8, 1999); Committee on Economic, Social and Cultural Rights, *Concluding Observations: Mauritius*, para. 15, U.N. Doc. E/C.12/1994/8 (May 31, 1994); Committee on Economic, Social and Cultural Rights, *Concluding Observations: Senegal*, para. 26, U.N. Doc. E/C.12/1/Add.62 (Sept. 24, 2001). *See also*, CENTER FOR REPRODUCTIVE RIGHTS, BRINGING RIGHTS TO BEAR 145-153 (2002), *available at* www.reproductiverights.org/pub_bo_tmb.html.
[22] Human Rights Committee, *Concluding Observations: Kenya*, para. 14, U.N. Doc. CCPR/CO/83/KEN (Apr. 29, 2005); Committee on the Rights of the Child, *Concluding Observations: Kenya*, para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007) [hereinafter CRC 2007 Concluding Observations: Kenya].
[23] CEDAW, *supra* note 13, at art. 1.
[24] The price for a safe abortion in private facilities in Kenya has been estimated to be approximately $625, while a "backstreet" abortion can be obtained for just $6.25. Joyce Mulama, *Contraceptives? You're Lucky if You Get Them*, INTER-PRESS SERVICES, GLOBAL INFORMATION NETWORK, Nov. 8, 2004 [hereinafter Mulama, *Contraceptives?*], *available at* http://ipsnews.net/interna.asp?idnews=26165.
[25] E.B. Wamwana et al., *Socio-Demographic Characteristics of Patients Admitted with Gynaecological Emergency Conditions at the Provincial General Hospital, Kakamega, Kenya*, EAST AFRICAN MEDICAL JOURNAL VOL. 83 NO. 12 659 (2006) (citing Misuse M.L. & Tlebera P., *Unsafe abortion and postabortion family planning in Africa: The case of Lesotho*, 1 AFR. J. OF FERTILITY, SEXUALITY & REPRODUCTIVE HEALTH 26-28 (1996)) [hereinafter Wamwana et. al].
[26] MINISTRY OF HEALTH [KENYA], A NATIONAL ASSESSMENT OF THE MAGNITUDE AND CONSEQUENCES OF UNSAFE ABORTION IN KENYA XI (2004).
[27] *Id.* at 21.
[28] Wamwana et. al., *supra* note 25, at 661.
[29] *Id.* at 660. The study concluded that the situation could be addressed by providing stronger community based health care, stronger referral systems, and better transport infrastructure. *Id.* at 665.
[30] CEDAW, *supra* note 13, at art. 12(1).
[31] *Id.* at art. 16(1)(e).
[32] Jane Godia, *Threatened Lives*, THE STANDARD, Nov. 14, 2004, at 20; Mulama, *Contraceptives?*.
[33] FIDA Kenya/CRR interviews and focus groups, Nov. 15, 2006, Nov. 16, 2006, Nov. 24, 2006, Nov. 28, 2006, Nov. 29, 2006, Feb. 1, 2007, Feb. 6, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 20, 2007.
[34] Joyce Mulama, *Too Many Illegal Abortions, Too Little Contraception*, MAIL & GUARDIAN ONLINE, Oct. 23, 2005 *available at* www.mg.co.za/articlePage.aspx?articleid=254381&area=/insight/insight__africa/.

[35] KDHS 2003, *supra* note 1, at 110.
[36] *Id.* at 68.
[37] *Id.*
[38] *Id.* at 106.
[39] *Id.* at 211.
[40] *Id.* at 61.
[41] *Id.*
[42] *Id.* at 95.
[43] DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH [KENYA], ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY: PLAN OF ACTION 2005-2015 3 (2005).
[44] CRC 2007 Concluding Observations: Kenya, *supra* note 22, para. 49.
[45] *Id.* at paras. 25, 50.
[46] CEDAW General Recommendation No. 24, *supra* note 3, at para. 18.
[47] KDHS 2003, *supra* note 1, at 194.
[48] *Id.* at 187.
[49] Kenya Government Report, *supra* note 6, at para.130.
[50] KDHS 2003, *supra* note 1, at 221.
[51] *Id.*
[52] Focus group discussions, Kisumu, April 5, May 31, June 1, 2007.
[53] HORIZONS REPORT, HIV/AIDS OPERATIONS RESEARCH, ABCS: NOT AS SIMPLE AS THEY SOUND: KENYA STUDY HIGHLIGHTS HOW ADULTS AND YOUTH INTERPRET KEY MESSAGES 9 (Dec. 2005).
[54] *Id.* For example, when asked to define "being faithful," respondents equated the term with qualities like "loyalty to another person or being honest and trustworthy," rather than sexual fidelity.
[55] *Id.* at 10.
[56] *Kenyan First Lady in AIDS Storm*, BBC NEWS, May 19, 2006.
[57] UNICEF, EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE 32 (2005).
[58] Shelley Clark, *Early Marriage and HIV Risks in Sub-Saharan Africa*, 35 STUD. FAM. PLAN. 149, 150 (2004).
[59] *Id.* at 149.
[60] *Id.*
[61] The Children Act of 2001 prohibits the marriage of any child and defines child as being under 18. The Children Act, No. 8 (2001), KENYA GAZETTE SUPPLEMENT NO. 95 §§ 2, 14.
[62] The Marriage Act, Cap. 150 (Kenya).
[63] The Hindu Marriage and Divorce Act, Cap 157 (Kenya).
[64] Vicky W. Mucai-Kattambo, Janet Kabeberi-Macharia & Patricia Kameri-Mbote, *Law and the Status of Women in Kenya*, *in* WOMEN, LAWS, CUSTOMS AND PRACTICES IN EAST AFRICA – LAYING THE FOUNDATION (Janet Kabeberi-Macharia, ed.) (1995).
[65] CRC 2007 Concluding Observations: Kenya, *supra* note 22, paras. 22, 53-54.
[66] CEDAW, *supra* note 13, at art. 1 (emphasis added).
[67] CEDAW General Recommendation No. 19, *supra* note 20, at para. 6.
[68] CEDAW, *supra* note 13, at art. 2(d)-(e) ("States Parties ... undertake ... [t]o refrain from engaging in any act or practice of discrimination against women and ensure that public authorities and institutions shall act in conformity with this obligation [and to] take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.").
[69] CEDAW General Recommendation No. 19, *supra* note 20, at para. 6.
[70] Kenya Government Report, *supra* note 6, para.194.
[71] KDHS 2003, *supra* note 1, at 132.
[72] CEDAW Committee, *Concluding Observations: Kenya*, para. 224, U.N. Doc. A/58/38 (Mar. 20, 2003) [hereinafter CEDAW 2003 Concluding Observations on Kenya].
[73] Kenya Government Report, *supra* note 6, at para. 125 (stating that "48.3% of the rural poor did not seek medical care when they are sick due to inability to cover the cost of medical care").
[74] Questionnaire respondent, Kisumu, Apr. 4, 2007.
[75] RICARDO BITRÁN & URSULA GIEDION, WAIVERS AND EXEMPTIONS FOR HEALTH SERVICES IN DEVELOPING COUNTRIES 75 (Social Protection Unit, The World Bank, Social Protection Discussion Paper Series No. 0308, Mar. 2003), *available at* http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-

papers/Safety-Nets-DP/0308.pdf (The paper's authors emphasize that their findings and analysis are preliminary and should not be attributed to the World Bank.)

[76] *See, e.g.*, Focus group discussions with unnamed participants, Nairobi, Apr. 13, 2007 ("There were women who couldn't go to the labour ward because they had not paid. They were giving birth outside."); Peter Kimani, *Tiny miracles that survive gigantic odds*, THE NATION, Jan. 18, 2005 (documenting accounts of women dying "on the waiting bench because they could not raise a modest admission fee").

[77] Zeddy Sambu, *Struggle to rescue image of Pumwani Hospital through improved services*, THE NATION, Dec. 7, 2005 at 11.

[78] Waweru Mugo, *Mayor promises action on deaths*, THE NATION, Nov. 7. 2000.

[79] Focus group discussion unnamed participant, Kisumu, Apr. 5, 2007.

[80] FIDA Kenya/CRR interviews and focus groups, Nov. 15, 2006, Nov. 24, 2006, Feb. 1, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 17, 2007, Apr. 20, 2007.

[81] Eric Wamanji, *The plight of little angels and their detained mothers*, THE STANDARD, June 3, 2007.

[82] International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, art. 10, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

[83] CEDAW, *supra* note 13, at art. 12(2).

[84] CRC 2007 Concluding Observations: Kenya, *supra* note 22, paras. 48, 52.

[85] KDHS 2003, *supra* note 1, at 129.

[86] NATIONAL JOINT STEERING COMMITTEE FOR MATERNAL HEALTH IN KENYA 2002, STANDARDS FOR MATERNAL HEALTH IN KENYA 7 (2002).

[87] KSPAS 2004, *supra* note 7; KDHS 2003, *supra* note 1; FIDA Kenya/CRR interviews and focus groups, Kenya, Nov. 15, 2006, Nov. 24, 2006, Nov. 28, 2006, Nov. 29, 2006, Feb. 1, 2007, Feb. 2, 2007, Feb. 6, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 11, 2007, Apr. 17, 2007, Apr. 20, 2007.

[88] FIDA Kenya/CRR interviews and focus groups, Kenya, Nov. 15, 2006, Nov. 24, 2006, Nov. 28, 2006, Nov. 29, 2006, Feb. 1, 2007, Feb. 2, 2007, Feb. 6, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 11, 2007, Apr. 17, 2007, Apr. 20, 2007.

[89] Focus group discussion unnamed participant, Nairobi, Feb. 9, 2007.

[90] Waweru Mugo & Martin Mutua, *Pumwani Hires 100 Nurses to Curb Staff Shortage*, THE STANDARD Dec. 22, 2004; Mike Mwaniki, *100 More Nurses for Pumwani*, THE NATION, Dec. 23, 2004; Jeff Otieno, *Babies Probe Turns to Pumwani*, THE NATION, Sept. 10, 2004; Julius Bosire, *Study Unveils Pumwani's Pathetic State*, THE NATION, Aug.10, 2004; Editorial, *Pumwani Needs a Total Overhaul*, THE NATION, Dec. 9, 1999; Lucy Oriang. *Maitha, Get Cracking on This Horror*, THE NATION, Nov. 6, 2004; Editorial, *Kombo on Pumwani*, THE STANDARD, Dec. 21, 2004; FIDA Kenya/CRR interviews and focus groups, Kenya, Nov. 15, 2006, Nov. 24, 2006, Nov. 28, 2006, Nov. 29, 2006, Feb. 1, 2007, Feb. 6, 2007, Feb. 9, 2007, Apr. 5, 2007, Apr. 11, 2007, Apr. 17, 2007, Apr. 20, 2007.

[91] *Id.*

[92] CEDAW General Recommendation No. 19, *supra* note 20, at paras. 6, 7.

[93] ICESCR, *supra* note 82, at art. 10(2).

[94] Focus group discussion unnamed participant, Kisumu, June 1, 2007.

[95] Focus group discussion unnamed participant, Kisumu, June 1, 2007.

[96] Focus group discussion unnamed participant, Kisumu, June 1, 2007.

[97] Focus group discussion unnamed participant, Kisumu, June 1, 2007.

[98] CEDAW 2003 Concluding Observations on Kenya, *supra* note 72, at para. 222.