CENTER
FOR
REPRODUCTIVE
RIGHTS

May 2, 2007

The African Commission on Human and Peoples' Rights

Re: Supplementary information on Kenya scheduled for review by the African Commission on Human and Peoples' Rights during its 41st Session

Dear Members of the Commission:

This letter is intended to serve as a supplement to the report submitted by Kenya to the African Commission on Human and Peoples' Rights as per Article 62 of the African Charter on Human and Peoples' Rights [African Charter],[1] which will be reviewed by the African Commission in its 41st ordinary session. The Center for Reproductive Rights (CRR), an international non-governmental organization and the Federation of Women Lawyers – Kenya (FIDA Kenya), a national women's rights non-governmental organization based in Kenya, hope to further the work of the African Commission by providing independent information concerning the rights protected in the African Charter. The letter also refers to the African Charter on the Rights and Welfare of the Child [Children's Charter],[2] which Kenya has ratified, and the Protocol of the African Charter on Human and Peoples' on the Rights of Women in Africa [Maputo Protocol][3] where these instruments can give further content to these rights. Contrary to the government's report,[4] Kenya has only signed and not ratified the Maputo Protocol at the time of this submission. This letter highlights several areas of concern relating to the status of reproductive health and rights of women and girls in Kenya, with a focus on access to key reproductive health services and freedom from gender-based violence.

The commitment of states parties to ensure reproductive rights should receive serious attention because these rights are fundamental to women's and girls' equality and health. The African regional system has offered the most explicit recognition and protection of these rights through the Maputo Protocol. While Kenya has not yet ratified the Maputo Protocol, its signature obliges it not to act in a way that undermines "the full realisation of the rights herein recognized."[5] Furthermore, the key human rights provisions that protect the sexual and reproductive rights of women—the rights to life, health, dignity, and non-discrimination, among others—are included in the African Charter. The African Charter requires states to take appropriate measures to ensure that discrimination against women is eliminated and that women's health is protected.[6] It also obliges states parties "to ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[7] The Children's Charter similarly protects girls.

Despite the human rights protections contained in these regional charters and protocols, and in the international treaties Kenya has ratified, 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 African Commission's attention the following areas of concern, which affect the reproductive health and rights of women and girls.

CENTER FOR REPRODUCTIVE RIGHTS
120 WALL STREET
NEW YORK, NEW YORK 10005
TEL 917 637 3600 FAX 917 637 3666
WWW.REPRODUCTIVERIGHTS.ORG

FEDERATION OF WOMEN LAWYERS-KENYA
AMBOSELI ROAD OFF GITANGA ROAD
P.O. BOX 46324 NAIROBI, KENYA
TEL/FAX 573511, 570444, 569956
WWW.FIDAKENYA.ORG

I. THE RIGHT TO REPRODUCTIVE HEALTH CARE (ARTICLES 2, 4, AND 16 OF THE AFRICAN CHARTER)

Article 4 of the African Charter guarantees the right to life, while Article 16 recognizes the right to enjoy the best attainable state of physical and mental health and obligates states parties to take necessary measures to ensure their people's health.[8] Existing international human rights standards on the guarantee of the right to life have been interpreted to require the government to take "positive measures" aimed at preserving life.[9] Such measures should respond equally to the needs of men and women in keeping with Articles 2 and 3 of the African Charter, which guarantee equality before the law and equal enjoyment of the rights and freedoms recognized in the Charter.

These clauses obligate the Kenyan government to ensure women's access to reproductive health services. In the absence of these services, women may experience unsafe pregnancies, possibly resulting in death or illness due to inadequate maternal health care. In cases of unwanted pregnancies, women may seek out unsafe illegal abortions that could also result in complications or death.

The government of Kenya recently increased funding for the health sector, allocating 9.4% of its gross domestic product, or Sh 43 billion (approximately USD 582 million), to the Ministry of Health budget. This is an increase of Sh 13 billion (approximately USD 176 million) from the previous year.[10] However, this allocation still falls short of the 2001 commitment made by African heads of state and the government of the Organization of African Unity (now the African Union) to allocate 15% of annual national budgets to bettering health services.[11]

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. [12] 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 rights to life, personal liberty and security, freedom from inhuman and degrading treatment, health, education, information, and freedom from discrimination. The African Charter, the Children's Charter, and the Maputo Protocol guarantee all these rights.

The committees that monitor compliance with the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) have framed the issue of maternal mortality as a violation of women's right to health and right to life.[13] The Human Rights Committee, the treaty-monitoring body of the ICCPR, has noted that the inherent right to life should not be understood in a restrictive manner and that states parties should take positive measures, particularly to increase life expectancy.[14]

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.[15]

Reduction of maternal mortality is also one of the major goals of several recent international conferences and has been included in Goal 5 of the Millennium Development Goals (MDGs) agreed to by Kenya.[16]

In its report, the government states that it "plans to improve maternal health services through promotion of safe motherhood,"[17] 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.[18] Furthermore, its stated goal of reducing the maternal mortality rate by only 30 deaths per 100,000[19] is wholly insufficient and comes nowhere close to the MDG goal of reducing the maternal mortality ratio by three quarters between 1990 and 2015.[20] In reference to taking concerted efforts toward achieving the MDGs, the Special Rapporteur on the Right to Health has commented:

> The Special Rapporteur is asking no more than that the world honour what it signed up to in 2000 and re-affirmed in September 2005. This is extremely important because, over the last two decades, many health systems have been seriously neglected. Many have suffered from chronic under-investment. Far from being improved and strengthened, many health systems have been undermined and weakened.[21]

The 2003 Kenya Demographic and Health Survey [2003 KDHS] estimates of adult mortality show a substantial rise in adult mortality since 1998.[22] At younger ages (15–34), women's mortality is higher than men's, most likely due to the HIV/AIDS pandemic.[23] According to the 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.[24] 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.[25] The government's own report cites the current maternal mortality rate as 590 per 100,000.[26] Currently, maternal deaths account for 15% of all deaths to women aged 15 to 49.[27] 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 disability 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.[28] 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.[29]

While ante-natal and post-natal care are technically free in Kenyan public health facilities, delivery services are not. User fees, in general, tend to hit women harder than men. As the government's report notes, poverty affects women more than men and female-headed households are worse off than other households.[30] According to the 2003 KDHS, low-income, rural, and less-educated women are least likely to receive delivery assistance from medical professionals.[31] 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.[32]

In recent interviews conducted by FIDA Kenya and CRR, health care providers and health care users confirmed that detention in health facilities for inability to pay is an ongoing practice that occurs in both public and private health facilities.[33] Such a practice violates a range of human rights, including the right to dignity and the right to liberty and security of the person. The practice of detaining patients who are unable to pay their medical bills 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 international human rights law provision for special protection of mothers during and for a reasonable period before and after childbirth.[34] Kenya is required to remedy any such discrimination, in both the public and private sector.[35] In its 2007 Concluding Observations, the Children's Rights Committee, which oversees compliance with the Convention on the Rights of Children (CRC), recommended that the Kenyan government give all pregnant women health and social services free of charge.[36]

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."[37] Furthermore, the government recognized in its Maternal Care Standards that "good quality care provides a woman with dignity during childbirth."[38] However, the results of the 2004 KSPAS, 2003 KDHS, and the interviews and focus groups conducted for an upcoming 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.[39]

Women who delivered their children in medical facilities described egregiously substandard medical services, negligent and abusive treatment at the hands of health care providers, and serious human rights abuses.[40] 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. In addition, women reported being pinched, slapped, or beaten into compliance during labor. Numerous women also reported rights violations occurring around the vaginal 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.[41] 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.[42] The Kenyan government must implement proper measures to both prevent and remedy the rights violations suffered by women during this time of great vulnerability.

C. 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. As in most African nations, it 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].[43]

In addressing abortion, the government's report comments under the right to life only that "existing laws stipulate that abortion is illegal," but that the law "provides for exceptional circumstances" where the pregnant woman's life is at risk.[44] These statements and the other brief discussions of maternal mortality and women's health in the government report fail to recognize that by forcing women to undergo unsafe clandestine abortions, Kenya's restrictive abortion law itself threatens women's rights to life and health, as guaranteed under Articles 4 and 16 of the African Charter. The importance of access to safe abortion for safeguarding women's lives is also clearly elaborated in the Maputo Protocol, which provides the most explicit articulation of the right to abortion in cases of sexual violence, when continued pregnancy endangers the mental and physical health or life of the pregnant woman, or when there is a fatal fetal anomaly.[45]

The committees that oversee compliance with the ICCPR, ICESCR, CEDAW, and the CRC have all characterized high rates of maternal mortality caused by abortion as violations of the rights to health and life, and have explicitly asked states parties to review legislation criminalizing abortions.[46] 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.[47]

Restrictive abortion laws also discriminate against women on the basis of sex, age, and economic status, violating the right to be free from discrimination as elaborated in Articles 2, 3, and 18(3) of the African Charter and Article 2(1) of the Maputo Protocol.[48] 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.[49] 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 in Kakamega Provincial Hospital found that factors contributing to unsafe abortion included educational needs, failed contraception, stigma attached to child bearing out of wedlock, lack of support from spouse/family, religion, and lack of family planning services for adolescents.[50]

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%.[51] This same report estimated that 20,000 women are

treated in public hospitals annually with abortion-related complications.[52] Unsafe abortion is the cause of 30 to 40% of maternal deaths in Kenya, according to the Kenya Medical Association and the Kenya Obstetric and Gynecological Society.[53] The Kakamega study found that abortion accounted for 43% of all cases admitted with acute gynaecological conditions,[54] and that an average of 91 bed-hours are necessary to treat abortion complications (compared to 39 bed-hours for other acute gynaecological complications).[55]

D. ACCESS TO 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.

Article 16(1) of the African Charter requires governments to ensure the best attainable standard of health for their citizens.[56] Similarly, Article 14(1) of the Children's Charter ensures the right to "the best attainable state of physical, mental and spiritual health."[57] The Maputo Protocol reaffirms this right in Article 14.[58] Existing international human rights standards also recognize women's right to "the highest attainable standard of health"[59] and to equality in "access to health care services, including those related to family planning."[60] Among the international human rights treaties that bind Kenya, women's right to family planning is expressly recognized in CEDAW and the CRC.[61]

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.[62] In FIDA Kenya/CRR interviews, women and health care providers also reported numerous obstacles to getting contraceptives such as 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.[63] All these factors create barriers to contraceptive use, which in turn result in unwanted pregnancies and unsafe abortions.[64] The KDHS 2003 shows that only 39% of all Kenyan women surveyed were using some form of contraceptive.[65] According to the survey, the steady increase of contraceptive use among married women since the 1980s slowed considerably after 1998.[66] The KDHS 2003 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%.[67] The survey also showed 20.5% of births to women under 20 are unwanted and another 26% are mistimed.[68] In addition, the KDHS 2003 found that only 12% of women and 10% of men aged 15-19 used a condom during their first sexual encounter.[69]

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 segments of the female population irrespective of age and education.

The right to sexual and reproductive health education is covered under Article 9 of the African Charter, framed as a right of access to information.[70] This right—which is further supported by guarantees of the rights to life, health, and autonomy in reproductive decision making—obligates the Kenyan government to ensure women's and adolescents' access to reproductive health information. Article 14(1)(f) of the Maputo Protocol, which provides a more detailed articulation of government obligations around family planning, includes the right to have family planning education[71] and obligates states parties to "provide adequate, affordable and accessible health services, including information, education and communication programs to women especially those in rural areas."[72]

Among the international treaties that the Kenyan government has ratified, CEDAW guarantees women not only the rights to "appropriate services in connection with pregnancy"[73] and to "decide freely and responsibly on the number and spacing of their children,"[74] but also "access to the information, education and means to enable them to exercise these rights."[75] The CRC also affirms women's right to "necessary medical assistance and health care,"[76] to "appropriate pre-natal and post-natal health care for mothers,"[77] and to "family planning education and services."[78]

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.[79] 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.[80]

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"[81] 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."[82] However, 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.

Statistics show that of the adolescents surveyed for the 2003 KDHS, 14.5% of girls and 30.9% of boys had their first sexual encounter by the time they reached age 15.[83] The KDHS found a strong relationship between age of sexual debut and educational level attained, particularly for women. While 25% of women aged 15-24 with no education had sex by age 15, only 4% with at least some secondary education did so.[84] Moreover, young people in Kenya often have trouble getting contraception or information about safe sex, which can lead to high rates of STIs including HIV, unplanned pregnancy, unsafe abortion, and maternal deaths.

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.[85] 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.[86]

E. 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. Article 14(1)(d) of the Maputo Protocol expressly articulates that women have the right to self-protection and to be protected against STIs including HIV/AIDS.[87] The Maputo Protocol also articulates a state's duty to protect girls and women from practices and situations that increase their risk of infection, such as child marriage.[88]

Existing international human rights standards on the right to equality, to the highest attainable standard of health, and to life have all been interpreted to indirectly guarantee women's rights in relation to HIV/AIDS. The CEDAW Committee has acknowledged that inequality and discrimination against girls and women, such as low economic status and sexual violence, play a role in making women more vulnerable to HIV infection.[89] The Children's Rights Committee has made the link between the practice of child and forced marriage and the spread of HIV/AIDS to adolescent girls.[90]

As the government's report notes, HIV/AIDS affects more women than men in Kenya.[91] 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.[92] HIV prevalence among women 20-24 is over three times that of men in the same age group (9% and 2% respectively).[93] However, knowledge of HIV/AIDS risk factors and prevention measures is erratic and comprehension of transmission and prevention routes is especially dismal. More than half of all young women aged 15-19 believe they have no chance of getting HIV and 43.5% of men of the same age share that belief.[94] 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.[95]

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 revealed that these terms are misunderstood by the groups they are meant to target.[96] 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.[97] Especially worrisome was the finding that two thirds of youth respondents felt that condoms were bad and that they may be "ineffective."[98] This study indicates that ABC programs are not clearly communicating vital information that adolescents need to protect themselves from HIV. (This situation was not improved when Lucy Kibaki, Kenya's first lady and chair of the 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."[99]) 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.[100] 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%).[101] The study also found that early

marriage increases frequency of sex, decreases condom use, and makes it harder for girls to abstain from sex.[102] Additionally, husbands of married girls were three times more likely to be HIV-positive than sexual partners of unmarried girls.[103]

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,[104] the Marriage Act[105] and the Hindu Marriage and Divorce Act[106] 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.[107] 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.[108]

II. VIOLENCE AGAINST GIRLS AND WOMEN, INCLUDING FEMALE GENITAL MUTILATION (ARTICLES 2, 3, 4, 5, AND 18 OF THE AFRICAN CHARTER)

Article 5 of the African Charter provides for respect of dignity and prohibits torture and inhuman or degrading treatment.[109] The Charter also guarantees the rights to life and health.[110] All these rights are violated when women have no protection from rape, domestic violence, and other forms of violence. Furthermore, Articles 2, 3 and 18(3)—which provide for the equal protection for both sexes of the Charter's rights and prohibit discrimination against women—are violated where governments fail to enact and enforce laws protecting women's physical safety and integrity.[111] Several provisions of the Children's Charter and the Maputo Protocol also protect women and girls from physical and emotional violence. Article 27 of the Children's Charter requires states parties to take measures to protect the child against all forms of sexual abuse, exploitation, torture, and inhuman and degrading treatment, including physical and mental injury and sexual abuse.[112] Further, Article 21 requires states parties to take action to eliminate harmful social and cultural practices.[113] Similarly, Article 3(4) of the Maputo Protocol requires states parties to take measures to protect women from all forms of sexual violence.[114]

A. SEXUAL AND DOMESTIC VIOLENCE

The Kenyan government's report acknowledges the prevalence of violence against women and girls.[115] While both domestic and sexual violence are widely under-reported, making it difficult to gather fully comprehensive statistics on their prevalence, figures indicate that these are serious blights on the lives of Kenyan women and adolescents. According to police sources, 2,908 cases of rape were reported for 2004[116] and 2,867 for 2005, but hospital statistics indicate that approximately 16,000 cases of rape occur each year.[117] In a 2003 survey of 1652 Kenyan women between the ages of 17 and 77, 52% reported being sexually abused in their lifetime, while over 30% of the surveyed women reported an experience of forced sexual intercourse in their lifetime.[118] A study in Nairobi indicated that 4% of all HIV infections in girls are a result of rape.[119] Domestic violence also constitutes a serious threat to the lives and health of women in Kenya. According to the 2003 KDHS, 47% of ever-married women reported emotional, physical, or sexual abuse by their husbands, while 8% reported experiencing all three forms of violence by their current or most recent husband.[120]

Sexual violence is also evident in schools throughout Kenya, but very little is being done about it. While the action is often criminal in nature, the repercussion felt by the offending teacher is usually administrative, such as interdiction or suspension.[121] Inadequate administrative follow-up often results in the offending teacher's reinstatement, leading to continued abuse of schoolchildren. In 2004, a Kiambu

primary school justified the return of a teacher who admitted to molesting girls for three years on the grounds that he was a good teacher.[122] Poor investigations and prosecutions lead to a less than 10% conviction rate on cases that are reported to court.[123]

Sexual violence in school can result in negative physical and mental consequences for the abused girl. When a girl is raped there is always the possibility of her becoming pregnant or acquiring an STI, but the consequences go much further than that. Pregnant girls can be forced out of school and into early marriages or, as mentioned earlier, unplanned and unwanted pregnancies can lead to illegal, unsafe abortions. Sexual abuse by a teacher or school official can also lead to reluctance on the survivor's part to return to school or to excel in classes, out of fear of being noticed by her abuser.[124] These crimes often go unreported because the victim fears social stigma, negative repercussions at school, or further abuse at the hands of the investigating agency.

Some progress has been made in the legislative and law enforcement framework addressing gender-based violence. In May 2006, the Kenyan legislature passed the Sexual Offences Act 2006, which is referred to in the government's report.[125] While the act is an improvement over earlier piecemeal and inadequate laws on sexual violence, there are serious concerns with the new legislation, such as the exclusion of marital rape as a punishable offence. Furthermore, the act provides that any person who falsely alleges a sexual offence against another person is guilty of an offence and is liable to punishment equal to that for the offence complained of.[126] This provision could discourage reporting of cases of sexual violence for fear of being punished if the case fails—for instance, if poor police investigation results in an acquittal.

The pressing need for legislation addressing domestic violence continues; the proposed Family Protection (Domestic Violence) Bill that the government refers to in its report[127] has been languishing since 2001 and has yet to be adopted into law. The Domestic Violence Bill would be an important step forward as it defines domestic violence to include physical, sexual, and psychological abuse, and would allow courts to issue protective orders. It would also create a Family Protection Fund to help establish and maintain shelters and services for domestic violence victims. This fund would be extremely important because there are currently insufficient resources for women who suffer domestic violence.[128] For example, there are no government-run shelters for women fleeing from violent partners. However, even if the Domestic Violence Bill becomes law, an important legislative gap would persist because the bill does not explicitly address marital rape.

The National Guidelines for the Medical Management of Rape/Sexual Violence issued by the Ministry of Health's Division of Reproductive Health outline the importance of providing counseling, emergency contraception (EC), and post-exposure prophylaxis to prevent HIV infection (PEP) for victims of sexual violence, as well as the importance of properly gathering evidence that can be used in prosecution.[129] However, it appears that the guidelines are not widely disseminated or known and there are serious problems with access to both EC and PEP. As of May 2006, PEP was available in only seven of 73 government district hospitals and one of eight provincial hospitals.[130] While the government asserts that EC is widely available in government facilities,[131] its availability is limited by the fact that health facilities managed by Christian faith-based organizations, which comprise 30-40% of facilities in Kenya and an even higher percentage in some provinces,[132] do not provide EC even though some of them treat sexual violence survivors. These facilities assert that their religious beliefs do not permit them to provide EC but that they direct women to government facilities for EC.[133] However, a woman may not be able to access a government facility that provides EC at all or within the time period in which EC is effective, particularly during the vulnerable and difficult time following sexual assault. The ability to prevent unwanted

pregnancy in these cases is particularly crucial since Kenya's restrictive abortion law does not have an exception for pregnancy resulting from sexual violence.

Certain law enforcement practices also deter prosecution in cases of sexual violence. The P3 form, used by police and doctors to document sexual assault, must first be obtained from a police officer before the victim can be examined by a doctor. There have been reports of police officers charging for P3 forms although they are supposed to be free.[134] Given the poverty experienced by women in Kenya, especially in rural areas, these costs can be prohibitive and can effectively deny a woman access to justice. In cases where the perpetrator is a police officer, the need to acquire the P3 form from the police station can deter the victim from pursuing the case at all.[135] Furthermore, the courts tend to prefer evidence gathered by government doctors, who are frequently overstretched and unable to see the victim right away, especially in rural areas.[136] The National Guidelines for the Medical Management of Rape/Sexual Violence include a form that can be filled out to gather information for documenting physical evidence of sexual violence that can later be entered into a P3 form.[137] However, it is unclear how widely or effectively this form is being used or what kind of training health care providers have received on this aspect of the guidelines. Finally, a frequently cited barrier to the effective prosecution of sexual offences is the lack of sensitivity and commitment to prosecute on the part of the police.[138] Amnesty International has voiced concerns about the fairness, transparency, impartiality, and independence of police investigations of sexual assault in Kenya.[139]

B. FEMALE GENITAL MUTILATION (FGM)

Subjecting girls and women to FGM violates the right to be free from all forms of discrimination, the rights to life and physical integrity, the right to health, the right to freedom from torture and cruel, inhuman and degrading treatment, and children's right to special protections. While the African Charter does not specifically mention FGM, it protects all those rights.[140] Article 21 of the Children's Charter also seeks to protect children against FGM by noting: "States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices prejudicial to the health or life of the child; and (b) those customs and practices discriminatory to the child on the grounds of sex...."[141] Further, Article 16(1) of the Children's Charter obliges states parties to take measures to protect children from "all forms of torture, inhuman or degrading treatment and especially physical or mental injury...."[142] The Maputo Protocol affirms and reinforces the language of both charters by requiring states parties to take all appropriate steps to eliminate social and cultural patterns and practices that discriminate against women,[143] and specifically prohibits all forms of FGM and all cultural defenses of the practice.[144]

Similar provisions in international treaties ratified by Kenya have also been interpreted to include women's right to be protected from FGM. The CEDAW Committee, the Human Rights Committee, and the CESCR Committee have explicitly identified the practice of FGM as discriminating against women.[145] The Human Rights Committee has expressed concern about the life-long health consequences and high maternal mortality rates that may be attributed to FGM, and has called FGM a violation of the right to protection from torture and cruel, inhuman, and degrading treatment, and a violation of the right to life.[146] During the 2006 Day of the African Child, the Chairperson of the African Union Commission stressed that FGM was a form of violence against girls and called on member states to "make a solemn commitment to eliminate the practice and help the millions of children who continue to be victims of such devastating practices."[147]

FGM has physical as well as psychological health repercussions. It has been linked to obstetric complications and increased risk of death, both at the time of delivery and post-partum.[148] FGM can also make labor and delivery difficult for women—leading to prolonged obstructed labor, which is one of the leading causes of obstetric fistula.[149] The resulting leaking of feces and/or urine can devastate the lives of women who are heavily stigmatized and often shunned by their husbands, families, and communities.[150]

Performing FGM on children, defined as those under the age of 18, is outlawed in Section 14 of the Children Act 2001.[151] This act describes girls who are likely to be forced into FGM as children in need of special care and protection and provides for courts to take action against the perpetrators.[152] The law has been faulted, however, for not providing for punishment of offenders, and recent statistics indicate that the government needs to take further steps to ensure that the law is observed in practice.[153] Moreover, the fact that FGM of adult women is not prohibited has been criticized because women who reach age 18 without undergoing FGM can still be coerced into the practice.[154] The government recently missed a key opportunity to outlaw forcible FGM of adult women when such a provision was removed from the new sexual offences legislation.

In spite of the legal prohibition against performing FGM on children, the practice continues in many Kenyan communities. A study performed by the Centre for Human Rights and Democracy in Eldoret estimated that 6,000 girls in two provinces would undergo FGM during the December 2004 holidays.[155] According to the 2003 KDHS, 32% of the 8200 women participating in the survey had undergone FGM.[156] Rural women (36%) were more likely to have undergone FGM than urban women (21%).[157] The Minister of State for Home Affairs estimates that 38% of women have undergone FGM with that figure reaching 80 to 90% for girls and women in certain rural districts.[158] The 2003 KDHS found that 20.3% of the 1,856 girls aged 15-19 participating in the survey had undergone FGM.[159]

An additional concern is the "medicalization" of FGM, which could undermine efforts to stop the practice. Reports suggest that the awareness of the health risks involved with FGM is not leading parents to abandon the practice, but rather, to turn to medical professionals to perform the procedure.[160] Anti-FGM activists report that up to 90% of women in the Kisii community of Southern Kenya are being circumcised illegally by medical professionals.[161] Government authorities have denied that FGM is taking place in health facilities.[162]

III. QUESTIONS FOR THE GOVERNMENT OF KENYA

On the basis of this information, we respectfully request that the Commission raise the following questions on these issues with the government of Kenya:

1. When does the Kenyan government intend to ratify the Maputo Protocol? Does it plan to do so without reservations? What steps is the government taking to ensure that its reproductive rights obligations under regional and international human rights law are domesticated and implemented at the national level?

2. What measures is the government taking to comprehensively address maternal mortality and morbidity and to ensure that women have access to safe and affordable quality delivery services? What is the government doing to address the key service provision gaps identified in the 2004 KSPAS? What is being done to improve implementation of the waiver system and to ensure that women and their babies are not denied health services or detained in health facilities because of their inability to pay user fees?

3. What steps are being taken to address the neglect and abuse of women in health care facilities? What efforts have been made to redress the egregious rights violations, such as the abuses at Pumwani Maternity Hospital that have been reported in the national media? Does the government intend to establish an independent body to investigate and redress complaints?

4. What measures are being implemented to ensure access to quality family planning services and information, the lack of which is resulting in unwanted pregnancies, abortions, and maternal mortality? Specifically, what measures are being taken to ensure women affordable and convenient access to their preferred family planning method in settings that protect their rights to confidentiality and informed consent?

5. What measures are being taken to review the existing abortion laws, health policies, and guidelines to bring them in line with the international and regional human rights standards binding Kenya and to remove provisions regarding abortion from the penal code? What measures are being taken to promptly address the issue of unsafe abortion, which is one of the major causes of maternal mortality? What measures are being taken to ensure access to comprehensive post-abortion care for women and girls who have complications resulting from unsafe abortion?

6. What measures are being taken to ensure that age-appropriate sexual and reproductive health information is reaching all sectors of adolescents and women living in rural and urban areas? What measures are being taken to pay attention to those with lower levels of socio-economic status? What is being done to ensure the effective implementation of the Adolescent Reproductive Health and Development Policy?

7. What efforts have been made to ensure accurate and comprehensive information about HIV transmission and prevention is reaching all women and girls? What measures are being implemented to reduce the rate of early marriage and to ensure that Kenya's marriage laws are revised to adequately protect young women from HIV/AIDS, as recommended by the Children's Rights Committee?

8. Is the government committed to ensuring the fulfillment of the guidelines for the treatment of sexual violence survivors as issued by the Ministry of Health? Are medical professionals and law enforcement officers receiving the necessary training on these guidelines? Is the necessary funding being provided for dissemination and training? What measures are being taken to ensure that victims of sexual violence have access to emergency contraceptives and post-exposure prophylaxis as outlined in the guidelines? Is the government committed to providing appropriate funding to ensure the availability of such resources in health centers? Is the government taking steps to ensure that Christian-run facilities that treat victims of sexual violence begin stocking emergency contraception?

9. What measures are being taken to create an adequate institutional infrastructure to conduct proper investigations for sexual crimes? What measures are being taken to protect students from sexual violence and abuse at school? What steps does the government plan to take to enable children and girls to safely report sexual violations in the community and in school environments? What plans does the government have to collect age-specific data on rape and other cases of sexual violence? What current measures are being taken to ensure that the police and the judiciary are

sensitive to the needs of victims of sexual violence? More specifically, are steps being taken to ensure the formation of gender desks in police stations?

10. What measures are being taken to pass legislation that effectively protects victims of domestic violence, including marital rape? Are there plans to increase the number of shelters for women faced with violence within the family? Is the government committed to providing the funding that will ensure the availability of shelters for victims of domestic violence? What current measures are being taken to ensure that the police and the judiciary are sensitive to the needs of victims of domestic violence?

11. What legal measures are being taken to protect women's right to be free from FGM? Is the government committed to passing laws that provide punishment for offenders of the Children Act 2001? What steps have been taken to ensure that the Children Act 2001 is observed? How many arrests and prosecutions of violations of the Act have actually taken place? What is being done to address the needs of girls and women who have developed complications from FGM, including their reproductive health care needs? What measures are being taken to promote public awareness of the harmful nature of FGM? In its last report to the Children's Rights Committee, the government recognized the link between FGM and early marriage. In light of this link and the many risks early marriages pose to young girls, what is the government doing to ensure that its marriage laws are revised to prevent the practice?

There remains a significant gap between the provisions of the African Charter and the reality of women's reproductive health and lives in Kenya. We hope that this information is useful during the Commission's review of the Kenyan government's compliance with the provisions of the African Charter. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Elisa Slattery
Legal Adviser, Africa Program
Center for Reproductive Rights

Jane Onyango
Executive Director
Federation of Women Lawyers—Kenya

[1] African Charter on Human and Peoples' Rights, *adopted* June 26, 1981, O.A.U. Doc. CAB/LEG/67/3/Rev.5, 21 I.L.M. 58, art. 4 (1982) (*entry into force* Oct. 21, 1986) [hereinafter African Charter].

[2] African Charter on Rights and Welfare of the Child, (*adopted* July 11, 1990) OAU Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) [hereinafter Children's Charter].

[3] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, *adopted* July 11, 2003, O.A.U. Doc. CAB/LEG/66.6, art. 4(1) (*entry into force* Nov. 25, 2005) [hereinafter Maputo Protocol].

[4] Republic of Kenya, *Report on the African Charter on Human and Peoples' Rights*, June 2006, para. 17, *available at* http://www.achpr.org/english/_info/Kenyan%20report_eng.pdf. [hereinafter Kenyan Government Report].

[5] Maputo Protocol, *supra* note 3, art. 26.

[6] "The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions." African Charter, *supra* note 1, art. 18(3). "States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." *Id.* art. 16(2).

[7] *Id.* art. 18(3).

[8] "Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right." *Id.* art. 18(4). "Every individual shall have the right to enjoy the best attainable state of physical and mental health." *Id.* art. 16(1). "States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." *Id.* art. 16(2).

[9] Human Rights Committee, *General Comment 6: The right to life*, para. 5. (16th Sess., 1982), U.N. Doc. HRI\GEN\1\Rev.1 at 6 (1994), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument. [hereinafter HRC Gen. Comm. 6].

[10] Mike Mwaniki, *Sh 10 bn is Set Aside for Sexual Health Education*, THE NATION (NAIROBI), June 20, 2006.

[11] *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, OAU/SPS/Abuja/3* (2001) 6, *available at* www.un.org/ga/aids/pdf/abuja_declaration.pdf.

[12] CENTRAL BUREAU OF STATISTICS (CBS) [KENYA], MINISTRY OF HEALTH (MOH)[KENYA], AND ORC MACRO, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2003 236 (2004) [hereinafter KDHS 2003].

[13] IESCR Committee, *General Comment 14, The Right to the Highest Attainable Standard of Health*, para. 21 (22ND Sess., 2000) U.N. Doc. HRI/GEN /1/Rev.5 (2001), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument. *See, e.g., CEDAW Committee Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (Jan. 7, 1999); *Colombia*, para. 393, U.N, Doc A/54/38 (April 2, 1999); *Dominican Republic*, para. 337, U.N. Doc A/53/38 (May 14, 1998); *Madagascar* para. 244, U.N. Doc A/49/38, (Dec. 4, 1994).

[14] HRC Gen. Comm. 6, *supra* note 9, para. 5.

[15] Statement by Paul Hunt, Special Rapporteur on the Right to the Highest Attainable Standard of Health to the United Nations General Assembly, 19 October 2006, *available at* www2.essex.ac.uk/human_rights_centre/rth/docs/oral%20remarks%20of%20Paul%20Hunt%20GA%202006.doc.

[16] UNITED NATIONS, MILLENNIUM DEVELOPMENT GOALS Goal 5, "Improve Maternal Mortality", [hereinafter Millennium Development Goal 5], *available at* www.un.org/millenniumgoals/index.html. *See also Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15, 1995, U.N. Doc. A/CONF.177/20, art. 107(i), (1995), *available at* http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en (Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births.); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, U.N. Doc.

A/CONF.171/13/Rev.1, para. 8.21 (1995), *available at* www.un.org/popin/icpd/conference/offeng/poa.html.

[17] Kenyan Government Report, *supra* note 4, para.82.

[18] NATIONAL COORDINATING AGENCY FOR POPULATION AND DEVELOPMENT [KENYA], MINISTRY OF HEALTH [KENYA], AND CENTRAL BUREAU OF STATISTICS, [KENYA] AND ORC MACRO CALVERTON, MARYLAND, USA, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2004, 111 [hereinafter KSPAS 2004].

[19] Kenyan Government Report, *supra* note 4, para. 82.

[20] Millennium Development Goal 5, *supra* note 16.

[21] U.N. Econ. & Soc. Council [ESOSOC], Comm. on Human Rights, Report of the Special Rapporteur: The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, U.N. Doc E/CN.4/2006/48, (March 3, 2006), para. 16, *available at* http://daccessdds.un.org/doc/UNDOC/GEN/G06/114/69/PDF/G0611469.pdf?OpenElement.

[22] KDHS 2003, *supra* note 12, at 234.

[23] *Id.* at 235.

[24] *Id.* at 237.

[25] *Id.* at 237 ("The sampling errors around each of the estimates are large and, consequently, the two estimates are not significantly different; thus, it is impossible to say with confidence that maternal mortality has declined.").

[26] Kenyan Government Report, *supra* note 4, para. 4.

[27] KDHS 2003, *supra* note 12, at 237.

[28] KSPAS 2004, *supra* note 18, at 128-140.

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

[30] Kenyan Government Report, *supra* note 4, para.156.

[31] KDHS 2003, *supra* note 12, at 132.

[32] Ricardo Bitran and Ursula Giedion, *Waivers and Exemptions for Health Services in Developing Countries* 75 (Social Protection Unit, The World Bank, Working Paper No. 25987, March 2003), *available at* http://www-wds.worldbank.org (The paper's authors emphasize that their findings their findings and analysis are preliminary and should not be attributed to the World Bank.)

[33] FIDA Kenya/CRR interviews and focus groups, 11/15/06, 11/24/06, 2/01/07, 2/09/07, 4/05/07, 4/17/07, 4/20/07.

[34] Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), at 71, U.N. Doc. A/810 (1948), art. 2; International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, art. 2(2), U.N. Doc. A/6316 (1966), 999. U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR].

[35] ICESCR Committee, *General Comment 16: The Equal Right of Men and Women to the Enjoyment of all Economic, Social and Cultural Rights (Art.3)*, paras. 11-13, 15, 19 (34th Sess., 2005), U.N. Doc E/C.12/2005/4 (2005), *available at* http://www.ohchr.org/english/bodies/cescr/docs/CESCR-GC16-2005.pdf; Human Rights Committee, *General Comment 28: Equality of Rights Between Men and Women (Art.3)*, (68th Sess., 2000), U.N. Doc. HRI/GEN/1/Rev.5 (2001), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/13b02776122d4838802568b900360e80?Opendocument.

[36] *CRC Committee Concluding Observations: Kenya*, 44th Sess., paras. 48, 52, U.N. Doc CRC/C/KEN/CO/2 (February, 2 2007) [hereinafter Kenya CRC Concluding Obs. 2007].

[37] KDHS 2003, *supra* note 12, at 129.

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

[39] KSPAS 2004, *supra* note 18; KDHS 2003, *supra* note 12; FIDA Kenya/CRR interviews and focus groups, 11/15/06, 11/24/06, 11/28/06, 11/29/06, 2/01/07, 2/02/07, 2/06/07, 2/09/07, 4/05/07, 4/11/07, 4/17/07, 4/20/07.

[40] FIDA Kenya/CRR interviews and focus groups, 11/15/06, 11/24/06, 11/28/06, 11/29/06, 2/01/07, 2/02/07, 2/06/07, 2/09/07, 4/05/07, 4/11/07, 4/17/07, 4/20/07.

[41] 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*, DAILY 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, 11/15/06, 11/24/06, 11/28/06, 11/29/06, 2/01/07, 2/06/07, 2/09/07, 4/05/07, 4/11/07, 4/17/07, 4/20/07.

[42] *Id.*

[43] Kenya Penal Code, Provision 240. The Ministry of Health, in its guidelines on the care of survivors of rape and sexual violence, has indicated that abortion may be available when pregnancy is a result of rape. However, the legal basis for this policy is not explicit in existing legislation. DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH (KENYA), NATIONAL GUIDELINES: MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE 9 (2004) [hereinafter MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE].

[44]Kenyan Government Report, *supra* note 4, para. 26

[45]Maputo Protocol, *supra* note 3, art.14(2)(c).

[46] *See, e.g., CEDAW Committee Concluding Observations: Burundi*, 02/02/2001, U.N. Doc. A/56/38, para. 61; *Madagascar*, 12/04/94, U.N. Doc. A/49/38, para. 244; *Morocco*, 12/08/97, U.N. Doc. A/52/38/Rev.1, para. 68; *Namibia*, 12/08/97, *Zimbabwe*, 14/05/98, U.N. Doc. A/53/38, para. 159; *Belize*, 01/07/99, U.N. Doc. A/54/38, para. 56; *Colombia*, 04/02/99, U.N. Doc. A/54/38, para. 393; *Dominican Republic*, 14/05/98, U.N. Doc. A/53/38, para. 337; *Chad*, 24/08/99, U.N. Doc. CRC/C/15/Add.107, para. 30. *See, e.g., CRC Committee Concluding Observations: Chad*, 24/08/99, U.N. Doc. CRC/C/15/Add.107, para. 30; *Colombia*, 16/10/2000, U.N. Doc. CRC/C/15/Add.137, para. 48; *Guatemala*, 09/07/2001, U.N. Doc. CRC/C/15/Add.154, para. 40; *Nicaragua*, 24/08/99, U.N. Doc. CRC/C/15/Add.108, para. 35; *Nicaragua*, 20/06/95, U.N. Doc. CRC/C/15/Add.36, para. 19. *See, e.g., ICESCR Committee Concluding Observations: Cameroon*, 08/12/99, U.N. Doc. E/C.12/1/Add.40, para. 25; *Mauritius*, 31/05/94, U.N. Doc. E/C.12/1994/8, para. 15; *Senegal*, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, para. 26. *See* CENTER FOR REPRODUCTIVE RIGHTS (CRR)(ed.), BRINGING RIGHTS TO BEAR 145-153 (Center for Reproductive Rights 2002), *available at* www.reproductiverights.org/pub_bo_tmb.html. *See* 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), art.6 [hereinafter ICCPR]

[47] *CRC Committee Concluding Observations*: *Kenya*, para. 45, U.N. Doc. CRC/C/15/Add.160 (November, 7 2001); *Human Rights Committee Concluding Observations*: *Kenya*, para. 14, U.N. Doc. CCPR/CO/83/KEN (April 29, 2005), 83rd Session; Kenya CRC Concluding Obs. 2007, *supra* note 36, para. 49.

[48] African Charter, *supra* note 1, arts. 2,3,18(3); Maputo Protocol, *supra* note 3, art.2(1).

[49] The price for a safe abortion in private facilities in Kenya has been estimated to be approximately $625, while a "backstreet" abortion can be obtained for just $6.25. Joyce Mulama, *Contraceptives? You're Lucky if You Get Them*, INTER-PRESS SERVICES, GLOBAL INFORMATION NETWORK, Nov. 8, 2004, *available at* http://ipsnews.net/interna.asp?idnews=26165.

[50] E.B. Wamwana, MD, P.M. Ndavi, P.B. Gichangi, BSc, J.G. Karanja, *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), [hereinafter Wamwana et. al].

[51] MINISTRY OF HEALTH (KENYA), A NATIONAL ASSESSMENT OF THE MAGNITUDE AND CONSEQUENCES OF UNSAFE ABORTION IN KENYA XI (2004).

[52] *Id.* at 21.

[53] *Kenyan Medics Call for Legalization of Abortion to Reduce Maternal Deaths*, BBC MONITORING INTERNATIONAL REPORTS, Jan. 29, 2004.

[54] Wamwana et. al., *supra* note 50, at 661.

[55] *Id.* at 660. The study concluded that the situation could be addressed by providing a stronger community based health care, stronger referral systems, and better transport infrastructure. *Id.* at 665.

[56] Africa Charter, *supra* note 1, art. 16(1).

[57] Children's Charter, *supra* note 2, art. 14(1).

[58] Maputo Protocol, *supra* note 3, art. 14.

[59] Convention on the Rights of the Child, art. 6, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448, *entered into force* Sept. 2, 1990, *available* at http://www.unhchr.ch/html/menu3/b/k2crc.htm. [hereinafter CRC]. *See, e.g.*, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),

adopted Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 12, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; ICESCR, *supra* note 34, art. 12(1).

[60] CEDAW, *supra* note 59, art. 12(1).

[61] *See id.* arts. 10(h), 12(1); CRC, *supra* note 60, arts. 13(1), 24(2)(f).

[62] Jane Godia, *Threatened Lives*, SUNDAY STANDARD, Nov. 14, 2004, at 20; Joyce Mulama, *Contraceptives? You're Lucky if You Get Them*, INTER-PRESS SERVICE, GLOBAL INFORMATION NETWORK, Nov. 8, 2004.

[63] FIDA Kenya/CRR interviews and focus groups, 11/15/06, 11/16/06, 11/24/06, 11/28/06, 11/29/06, 2/01/07, 2/06/07, 2/09/07, 4/05/07, 4/20/07.

[64] 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/.

[65] KDHS 2003, *supra* note 12, at 68.

[66] *Id.*

[67] *Id.* at 106.

[68] *Id.* at 110.

[69] *Id.* at 211.

[70] African Charter, *supra* note 1, art. 9.

[71] Maputo Protocol, *supra* note 3, art. 14(1)(f).

[72] *Id.* art. 14(2)(a).

[73] CEDAW, *supra* note 59, art. 12(2).

[74] *Id.* arts. 12(2), 16(1)(e).

[75] *Id.* art. 16, para. 1(e).

[76] CRC, *supra* note 59, art. 24(2)(b).

[77] *Id.* art. 24(2)(d).

[78] *Id.* art. 24(2)(d).

[79] KDHS 2003, *supra* note 12, at 61.

[80] *Id.*

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

[82] *Id.*

[83] KDHS 2003, *supra* note 12, at 95.

[84] *Id.* at 209.

[85] Kenya CRC Concluding Obs. 2007, *supra* note 36, para. 49.

[86] *Id.* at paras. 25, 50.

[87] Maputo Protocol, *supra* note 3, art. 14(1)(d).

[88] *Id.* art. 14(1)(d)(e).

[89] CEDAW Committee, *General Recommendation 24: Women and Health*, paras. 6, 18 (20th Sess., 1999), U.N. Doc. HRI/GEN /1/Rev.5 (2001), *available at* http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm. *See, e.g., CEDAW* Committee *Concluding Observations*: *Rwanda*, 09/05/96, U.N. Doc. A/51/38, para. 321; *Uganda*, 31/05/95, U.N. Doc. A/50/38, para.322; *Namibia*, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, para.79.

[90] *CRC Committee Concluding Observations: Central African Republic*, 16/10/2000, U.N . Doc. CRC/C/15/Add.138, paras. 46–47; *Djibouti*, 28/06/2000, U.N. Doc. CRC/C/15/Add.131, paras. 45–46; *India*, 23/02/2000, U.N. Doc. CRC/C/15/Add.115, para. 50.

[91] Kenyan Government Report, *supra* note 4, para.156.

[92] KDHS 2003, *supra* note 12, at 221.

[93] *Id.* at 221.

[94] *Id.* at 194.

[95] *Id.* at 187.

[96] 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).

[97] *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.

[98] *Id.* at 10.

[99] *Kenyan First Lady in AIDS Storm*, BBC NEWS, May 19, 2006.
[100] UNICEF, EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE, 32, 2005.
[101] Shelley Clark, *Early Marriage and HIV Risks in Sub-Saharan Africa*, 35 STUD. FAM. PLAN. 149, 150 (2004).
[102] *Id.* at 149.
[103] *Id.*
[104] The Children Act of 2001 prohibits the marriage of any child and defines child as being under 18. *See* Kenya Gazette Supplement No. 95 (Acts. No. 8), The Children Act, 2001, secs. 2, 14.
[105] The Marriage Act, Cap. 150 (Kenya).
[106] The Hindu Marriage and Divorce Act, Cap 157 (Kenya).
[107] 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).
[108] CRC Concluding Obs., *supra* note 36, paras. 22, 53-54.
[109] African Charter, *supra* note 1, art. 5 ("Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.").
[110] African Charter, *supra* note 1, art. 16(1) ("Every individual shall have the right to enjoy the best attainable state of physical and mental health."); *Id.* art. 4 ("Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.").
[111] *Id.* arts. 2, 3, 18(3).
[112] Children's Charter, *supra* note 2, art. 27.
[113] *Id.* art. 21.
[114] Maputo Protocol, *supra* note 3, art. 3(4).
[115] Kenyan Government Report, *supra* note 4, paras. 151-152.
[116] KENYA POLICE, RAPE CASES FOR THE YEARS 2000, 2001, 2002, 2003 AND 2004, KENYA POLICE INTERNAL STATISTICS 2000-2004.
[117] Mercy Randa, *Sexual Abuse Cases on Children Up*, NATION (NAIROBI), June 16, 2006.
[118] TONY JOHNSTON, POPULATION COMMUNICATION AFRICA, THE SEXUAL ABUSE OF KENYAN WOMEN AND GIRLS: A BRIEFING BOOK 6, 14 (2003).
[119] GENDER AND HIV/AIDS TECHNICAL SUB-COMMITTEE OF THE NATIONAL AIDS CONTROL COUNCIL, MAINSTREAMING GENDER INTO THE KENYA NATIONAL HIV/AIDS STRATEGIC PLAN 2000-2005 2 (2002).
[120] KDHS 2003, supra note 12, at 243. One study found that among 1267 women, 60.9% of Kenyan married women experience single or multiple abuses in their homes. Thirty-seven percent report multiple episodes; 23.9% report single episodes of domestic violence; 54% report frequent abuse; 52.2% of the surveyed women were abused physically; 40.7% reported sexual abuse and more than 64% reported psychological and emotional abuse. POPULATION COMMUNICATION AFRICA, DOMESTIC ABUSE IN KENYA 10 (2002).
[121] KENYA ALLIANCE FOR ADVANCEMENT OF CHILDREN, ET. AL., STATE VIOLENCE IN KENYA: AN ALTERNATIVE REPORT TO THE UNITED NATIONS HUMAN RIGHTS COMMITTEE 71 (2005).
[122] Njonjo Kihuria, *Suspected Molester Forgiven for being a 'Good Teacher,'* EAST AFRICAN STANDARD, Aug. 6, 2004.
[123] *Id.*
[124] HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS 61 (2001).
[125] Kenyan Government Report , *supra* note 4, para.142
[126] The Sexual Offences Act, S. 38 (Kenya).
[127] Kenyan Government Report, *supra* note 4, para.142.
[128] In rural communities, there are no shelters and little professional help for those experiencing domestic violence. The situation is not much better in urban areas. In the capital city of Nairobi, there is only one shelter where abused children can stay for up to six months and one shelter for abused women where they can stay for six weeks. The shelter for abused women is run by a non-governmental organization which is dependent upon donor funds.

[129] MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE, *supra* note 43.
[130] Joyce Mulama, *Preventing Rape Survivors from Becoming AIDS Statistics*, INTER PRESS SERVICE, May 22, 2006.
[131] *Id.*
[132] FIDA Kenya/CRR interview with Christian Health Association of Kenya, 11/20/2006.
[133] *Id.*; FIDA Kenya/CRR interview with Catholic Health Secretariat, 4/10/07.
[134] Monitors and chiefs in the field who work with FIDA Kenya have reported that in many rural areas, the standard fee to acquire the P3 form is 500 Kenyan shillings (approximately 6.25 U.S. dollars or 5.10 Euros) and an additional 500 shillings must be paid at the hospital to have the form filled out by a doctor. FIDA Kenya, Draft Memorandum to the Commissioner of the Police, Major-General Hussein Ali, Nov. 2004; *See also* Amnesty International, *Kenya: Rape: The Invisible Crime*, March 2002 [hereinafter Amnesty International], *at* http://web.amnesty.org/library/Index/engafr320012002.
[135] Amnesty International, *supra* note 134.
[136] SOCIETY FOR INTERNATIONAL DEVELOPMENT, PULLING APART: FACTS & FIGURES ON INEQUALITY IN KENYA 21 (2004) *available at* http://www.sidint.org/Publications/Docs/pulling-apart.pdf.
[137] MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE, *supra* note 43, 35-38.
[138] Amnesty International, *supra* note 133.
[139] *Id.*
[140] The right to be free from all forms of discrimination against women is guaranteed by Articles 2, 3 and 18(3) of the African Charter. The rights to life and physical integrity are protected by Article 4, and Article 16 provides protection for the right to health. African Charter, *supra* note 1.
[141] The Children's Charter also prohibits the practice of FGM by guaranteeing the right to life and "[t]he right to enjoy the best attainable state of physical, mental and spiritual health." Children's Charter, *supra* note 2, art. 21.
[142] *Id.* art. 16(1).
[143] Maputo Protocol, *supra* note 3, art. 8(f).
[144] *Id.* art. 5(b).
[145] The CEDAW Committee has identified the practice of FGM as discriminatory against women in its Concluding Observations on various countries. *See, e.g., CEDAW Committee Concluding Observations: Burkina Faso*, 31/01/2000, U.N. Doc. A/55/38, para. 261; *Cameroon*, 26/06/2000, U.N. Doc. A/55/38, paras. 53–54; *Democratic Republic of the Congo*, 01/02/2000, U.N. Doc. A/55/38, para. 215; *Netherlands*, 31/07/2001, U.N. Doc. A/56/38, para.207; *Senegal*, 12/04/94, U.N. Doc. A/49/38, para. 721. Furthermore, the CEDAW Committee's General Recommendation 19 draws a connection between traditional attitudes that subordinate women and violent practices such as FGM, stating that "such prejudices and practices may justify gender-based violence as a form of protection or control of women." CEDAW Committee, *General Recommendation 19: Violence against Women*, para. 11 (11th Sess., 1992), U.N. Doc. HRI/GEN /1/Rev.5 (2001), *available at* www.unhchr.ch/tbs/doc.nsf/(Symbol)/300395546e0dec52c12563ee0063dc9d?Opendocument. General Recommendation 19 also recognizes that violence against women not only deprives them of their civil and political rights, but also of their social and economic rights. It states, "[t]he underlying (structural) consequences of these forms of gender-based violence help to maintain women in their subordinate roles, contribute to their low level of participation and to their low level of education, skills and work opportunities." *Id.* Similarly, the Human Rights Committee has equated FGM with discrimination against women and girls. *See, e.g., Human Rights Committee Concluding Observations: Nigeria*, 24/07/96, U.N. Doc. CCPR/C/79/Add.65, A/51/40, paras. 291, 296; *Senegal*, 19/11/97, U.N. Doc. CCPR/C/79/Add 82, para. 12; *Zimbabwe*, 04/08/98, U.N. Doc. CCPR/C/79/Add. 89, para. 12; *Sudan*, 19/11/97, U.N. Doc. CCPR/C/79/Add.85, para. 10. The ICESCR Committee has also recognized the discriminatory aspects of the practice of FGM. *See, e.g., ICESCR Committee Concluding Observations: Cameroon*, 08/12/99, U.N. Doc. E/C.12/1/A dd.40, para. 33; *Egypt*, 12/05/2000, U.N . Doc . E/C.12/1/A dd.44, para. 13; *Nigeria*, 13/05/98, U.N. Doc. E/C.12/Add.23, para. 39. The ICESCR Committee's General Comment 14 explains that, "The right to health ... include[s] the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation." ICESCR Committee, *General Comment 14: The right to the highest attainable standard of health*, para. 8 (22nd Sess., 2000), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), *available at*

http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument. General Comment 14 imposes an obligation on states parties to take measures to protect women and children "in the light of gender-based expressions of violence," and to ensure that harmful traditional practices do not interfere with access to health care and family planning. *Id.*, para. 35.

[146] *See e.g., Human Rights Committee Concluding Observations: Lesotho*, 08/04/99, U.N. Doc. CCPR/C/79/Add.106, para. 12; *Senegal*, 19/11/97, U.N. Doc. CCPR/C/79/Add 82, para. 12.

[147] H.E. Prof Alpha Omar Konare, Chairperson of the African Union Commission, Statement on the Occasion of the Commemoration of the Day of the African Child (June 16, 2006), *available at* www.africaunion.org/root/au/Conferences/SpecialDays/2006/day_of_african_child/Statement_by_Chairperson.pdf.

[148] WHO Study Group on Female Genital Mutilation and Obstetric Outcome, *Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries*, 367 LANCET 1835, 1839 (2006).

[149] *Consequences of Genital Mutilation*, 36 WOMEN'S HEALTH NEWSL. 5 (1998); Rebecca Cook et al., *Obstetric Fistula: The Challenge to Human Rights*, 87 INT'L J. GYNAECOLOGY & OBSTETRICS 72 (2004).

[150] Maggie Bangser, *Obstetric Fistula and Stigma*, 367 LANCET 535 (2006).

[151] Kenya Gazette Supplement No. 95 (Acts. No. 8), The Children Act, 2001, sec.14.

[152] Kenya Gazette Supplement No. 95 (Acts. No. 8), The Children Act, 2001, sec.119(h).

[153] *See Kenya: Boost for Anti-FGM Efforts as 200 Circumcisers Quit*, UN INTEGRATED REGIONAL INFORMATION NETWORK, Mar. 10, 2004, *available at* www.irinnews.org/report.asp?ReportID=39965.

[154] Joyce Mulama, *Kenya: In the Name of Chastity, Girls Go Through Pain, Humiliation*, ALL AFRICA, Sept. 27, 2004; Ochieng' Ogodo, *FGM in Kenya: Outlawed, Not Eradicated*, INTER PRESS SERVICE, GLOBAL INFORMATION NETWORK, Feb. 8, 2005.

[155] *6,000 Girls Set To Be 'Cut' in North Rift*, DAILY NATION, Nov. 12, 2004.

[156] KDHS 2003, supra note 12, at 250.

[157] *Id.*

[158] Ogodo, *supra* note 154.

[159] KDHS 2003, *supra* note 12, at 251.

[160] IRIN NEWS, *supra* note 153.

[161] *Id.*; Joyce Mulama, *Kenya: Women Say Genital Mutilation Goes on Unabated*, INTER PRESS SERVICE-GLOBAL INFORMATION NETWORK, June 9, 2004.

[162] *Id.*