CENTER FOR REPRODUCTIVE RIGHTS

January 11, 2011

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

Re: Supplementary Information on Kenya Scheduled for Review during the 48th Session of the CEDAW Committee

Dear Committee Members:

This letter is intended to supplement the 7th periodic report of the government of Kenya, scheduled for review by this Committee during its 48th session. The Center for Reproductive Rights (CRR), an independent non-governmental organization based in New York which uses the law to advance reproductive freedom as a fundamental human right, and the Federation of Women Lawyers, Kenya (FIDA Kenya), a non-governmental organization committed to improving the legal standing of women in Kenya, hope to further the work of the Committee by reporting 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 reproductive and sexual health and rights of women and girls in Kenya. Reproductive and sexual rights are fundamental to women's health and social equality and an explicit part of the Committee's mandate under the CEDAW. The commitment of states to respect, protect and fulfill these rights deserves serious attention.

We wish to bring to the Committee's attention the following areas of particular concern: women's lack of access to reproductive healthcare and information, including information on HIV prevention and treatment; and discrimination and sexual violence against women, adolescents, and school girls. These problems reflect shortfalls in the government's implementation of CEDAW and directly affect the health and lives of women in Kenya. (This letter is accompanied by the executive summary of CRR's most recent fact-finding report, *In Harm's Way: The Impact of Kenya's Restrictive Abortion Law* (2010), which provides further context on reproductive rights in 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 access "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

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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)].

A. COST AS A BARRIER TO REPRODUCTIVE HEALTHCARE

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."[1] Healthcare costs can prevent or delay women from accessing services, and can also impose additional health risks and hardship. Informal and formal healthcare fees disproportionately affect low-income, rural, and less-educated women, who are least likely to receive delivery assistance from medical professionals.[2] In its 2007 Concluding Observations, the CEDAW Committee expressed concern at women's inability to access "quality sexual and reproductive health services" and urged Kenya "[to] increase women's access to health-care facilities and medical assistance by trained personnel, especially in rural areas."[3] However, as the government's report indicates, the cost of medical care is a significant barrier to women's access to healthcare.[4] A recent study on the costs of maternity care in Kenya revealed that the out-of-pocket cost of normal and complicated delivery care constitutes 17% and 35%, respectively, of the mean monthly household income in Kenya.[5] The study further suggests that poor women in Kenya may be disproportionately burdened: out-of-pocket costs for deliveries for women in the poorest quintile were higher ($20.30) than the mean amount paid by all women ($18.40).[6] In recognition of the barriers presented by user fees, the Committee on the Rights of the Child (Children's Rights Committee), which oversees compliance with the Convention on the Rights of the Child, recommended in its 2007 Concluding Observations that the Kenyan government give all pregnant women health and social services free of charge.[7]

Although Kenya has implemented a general waiver in public hospitals for people who cannot meet their medical costs, the process is often burdensome and healthcare workers are often reluctant to inform patients about the waivers because the facility providing the waiver has to absorb the costs.[8] A 2007 fact-finding report by FIDA Kenya and CRR confirmed that many women do not seek medical care because of the cost, while other women are denied entrance to health facilities because they cannot afford the requisite deposit.[9] Interviews with healthcare 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.[10] Such detention practices violate a host of fundamental rights, including the right to dignity and the right to be free from discrimination. These practices also disregard the amplified vulnerability of women who are pregnant or have recently given birth, as recognized by the special protections granted to women before, during, and after childbirth under international human rights law.[11]

B. 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. The Committee has recognized maternal mortality as a violation of women's rights to health and life[13] and stated 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."[14] 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."[15]

Reduction of maternal mortality is also one of the eight Millennium Development Goals (MDGs) agreed to by Kenya.[16] Kenya's commitment requires a reduction of the maternal mortality rate to 175 per 100,000 live births or less by 2015.[17] Yet, according to the 2008-2009 Kenya Demographic and Health Survey [2008-2009 KDHS], the maternal mortality ratio was 488 maternal deaths per 100,000 live births for the ten-year period prior to the survey.[18] Furthermore, the World Health Organization reports a higher maternal mortality ratio in Kenya, with a 2005 estimate of 560 per 100,000 live births.[19] As high as these numbers are, they do not capture the many instances of maternal morbidity where women 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).

In its seventh periodic report, the Kenyan government attributes the high maternal mortality rate to the physical and economic inaccessibility of healthcare which is further compounded by low doctor to patient ratios and high rates of poverty.[20] Although the Ministry of Health and National Coordinating Agency for Population and Development have identified maternal health as a priority issue, Kenya's most recent survey on service provision, the 2004 Kenya Service Provision Assessment Survey [2004 KSPAS], demonstrates that very few healthcare facilities in the country are fully equipped and prepared to provide comprehensive quality maternal healthcare.[21] Of the surveyed facilities which provide delivery services, only 40% had all the necessary infection control items; only 36% had all essential delivery supplies; only 26% had the necessary medicines and supplies for handling common complications; and only 13% were equipped to handle serious complications.[22]

The results of the 2004 KSPAS, 2008-2009 KDHS, and a fact-finding report by FIDA Kenya and CRR reveal an alarming degree of rights violations occurring in medical facilities.[23] The fact-finding report documents how women are subjected to substandard medical services and negligent and abusive treatment at the hands of healthcare providers.[24] Women recount rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[25] In its 2007 Concluding Observations, the CEDAW Committee mandated Kenya to "ensure that health workers adopt a client-friendly attitude that will lead to improved access to quality health care."[26]

C. ABORTION AND POST-ABORTION CARE (PAC)

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. Unsafe abortion is the cause of 35% of Kenya's maternal deaths[27] and over 2,600 women die every year in Kenya from complications of unsafe abortion.[28] A recent Kenyan study estimated that 21,000 women are treated in public hospitals annually with abortion-related complications.[29] More than 40% of those women "fall into the categories of probable or likely induced abortion"[30] and nearly 30% experience highly severe complications.[31] These statistics demonstrate unsafe abortion's terrible toll on Kenyan women's lives and the tremendous pressure it places on an already resource-strapped healthcare system. Yet, the government's report entirely fails to recognize, as the statistics above show, that unsafe abortion is one of the leading causes of maternal death in Kenya.[32]

Despite Kenya's stated commitment to reducing maternal mortality, its abortion law has long been among the most restrictive in the world. The lack of clarity surrounding Kenya's abortion law has

further complicated access to safe abortion. Although, until recently, the law permitted abortion only where there is a threat to the life of the pregnant woman, without regard to her age or the conditions under which she became pregnant,[33] other governmental agencies, such as the Ministry of Health and the Medical Practitioners and Dentists Board, had issued expansive interpretations of this life exception.[34] These interpretations allow for abortions to be lawfully performed in cases of risk to the woman's health or in some cases of rape. Yet, as a recent CRR fact-finding report makes clear, few healthcare providers are trained on the full content of the law and most women remain unaware of the law's exceptions. A lack of clarity about legal access to abortion has produced widespread misinformation among women, adolescents, and medical providers, denying many women access to safe abortion under the law.[35] With the recent promulgation of Kenya's new constitution in August 2010 the legal framework has improved: under the constitution's right to life provision abortion is now permitted if, "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger . . . ."[36] However, the current Kenyan law still does not provide an explicit exception in cases of rape and incest, in spite of the high rates of sexual violence and limited access to contraception; including emergency contraception [see Part I (C)].[37]

The constitutional clause on abortion, which plainly permits abortion in cases of danger to the woman's life or health,[38] is an important step in clarifying the existing legal and policy framework. However, a companion clause in the new constitution's right to life provision, stating that "[t]he life of a person begins at conception,"[39] reinforces the lack of clarity surrounding the legal status of this procedure. Despite the presence of clear constitutional exceptions to the criminalization of abortion, the Constitution's definition of when life begins may have a chilling effect on healthcare providers who find this clause contradictory and confusing and who do not want to risk being accused of violating a fetus' right to life when performing a legal abortion. Without penal code reform, clear implementing policies and regulations, and widespread education on the new constitution's provisions, the challenges associated with a lack of clarity surrounding Kenya's abortion laws and policies will remain.

The harsh impact of the restrictive and unclear abortion law is compounded by the difficulties faced by Kenyan women in obtaining access to post-abortion care (PAC), for often life threatening complications, after resorting to unsafe abortions. Barriers to access include the fear of prosecution, social stigma, and the prohibitive costs associated with obtaining PAC.[40] Women who cannot afford to pay for services report being involuntarily detained in healthcare facilities by hospital administrators.[41] In the event that women are able to overcome these obstacles and access care, the quality of care they receive is often substandard due to the lack of trained professionals capable of rendering PAC, negative provider attitudes, and inadequate pain management.[42] Women who experience verbal and physical abuse when attempting to access PAC do not have any meaningful method of obtaining redress. Although the Ministry of Health claims that PAC is a prioritized component of its national reproductive health strategy, it does not provide sufficient attention or institutional and monetary support to strengthen PAC services in Kenya.[43]

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."[44] The Committee has also repeatedly recognized the importance of PAC and has called for state parties to ensure "access to quality services for the management of complications arising from unsafe abortions."[45] Both the Human Rights Committee and the Children's Rights Committee have

specifically expressed concern over the criminalization of abortion in Kenya, including in cases of rape and incest, and its link to maternal mortality.[46]

Restrictive abortion laws also discriminate against women. 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.[47]

D. Access to Comprehensive Family Planning Services and Information

Access to family planning services and information is central to protecting women's 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 healthcare, 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.

In spite of this, access to contraception is highly limited by a number of factors including the government's failure to ensure an adequate and consistent supply of contraceptives, financial barriers, and discriminatory service provision caused by the stigma that surrounds women's and girls' sexuality in Kenya.[48] Kenya's public health facilities have experienced consistent shortages or "stock-outs" of contraceptives, caused in part by the government's inadequate budgetary allocations and the significant delays in securing the release of allocated funds from the treasury.[49] While private facilities are less likely to experience contraceptive stock-outs, most Kenyans cannot afford their prices.[50] Further, although the Ministry of Health's policy requires that contraceptives at government facilities and government-supplied contraceptives at private facilities must be free of charge, the latest government survey on the issue, the 2004 KSPAS, found that 42% of government facilities charged user fees for family planning services and 8% of government facilities charged for the contraceptive method itself.[51] Women and healthcare providers have 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.[52] Adolescents face additional barriers such as stigma and discrimination while trying to access contraceptives and even providers acknowledge the absence of youth-friendly family planning services.[53]

All these factors create barriers to contraceptive use, which in turn can result in unwanted pregnancies and unsafe abortions.[54] A 2009 Guttmacher Institute report notes that overall, more than 40% of births in Kenya are unplanned.[55] Among adolescents aged 15 – 19, nearly 50% of births are unplanned.[56] The report also indicates that 25% of married women were found to have an unmet need for family planning.[57] This statistic has barely changed over the course of a decade. [58] The 2008-2009 KDHS further reveals 17% of births are unwanted and 26% are mistimed.[59] Fully half of all births to women aged 40 – 44 were found to be unwanted.[60] Furthermore, the contraceptive prevalence rate among currently married women is only 46%.[61]

Access to emergency contraception (EC) in Kenya is also limited by insufficient supplies and negative provider attitudes.[62] Despite the clear public demand for EC, Kenyan public health facilities

are insufficiently stocked.[63] A Population Council study found that pharmacists demand a doctor's prescription before dispensing the medication, even though EC is an over-the-counter drug and not subject to such a restriction.[64] There are also misperceptions about the appropriate uses for EC. For instance, some healthcare providers believe that EC should only be available to rape victims, despite the fact that the 2008 Ministry of Health Guidelines on EC clearly state that it is intended to be used after unprotected sex and can safely be used by adolescents.[65] As a result, women report being arbitrarily denied EC on the basis of marital status and age as well as healthcare providers' personal perceptions of what constitutes "abuse" of EC.[66]

Family planning information and services must go hand-in-hand to be effective. 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."[67] However, accessible and accurate information about sex and reproductive health is limited in Kenya primarily by inadequate sexuality education in schools and insufficient government outreach on family planning methods.[68] Misinformation about sexuality and preventing unwanted pregnancy is widespread. The Director of Public Health and Sanitation at the Ministry of Health recently observed that the content of the sexual education curriculum in schools is so thin due to opposition from parents, religious organizations, and some civil society groups that much of the message regarding safe sex is not getting through to youths.[69] In its 2007 Concluding Observations on Kenya, the CEDAW Committee recommended that "sex education be widely promoted and targeted at adolescent girls and boys, with special attention to the prevention of early pregnancy and the control of sexually transmitted infections."[70]

Consequently, many Kenyans, particularly adolescents, are ill equipped to prevent unwanted pregnancies. The negative impact of lack of 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.[71] 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.[72]

II. VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS (ARTICLES 1, 2, 12, 14, AND 16)

States are obligated under CEDAW to take steps to eliminate sex-based discrimination by both public and private actors.[73] This requirement of non-discrimination permeates all of Kenya's duties under CEDAW, including the obligation "to eliminate discrimination against women in all matters relating to marriage and family relations…" [Article 16(1)]. 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.[74]

A. EARLY MARRIAGE

The high rate of early marriages in Kenya contributes to the vulnerability of adolescent girls to HIV infection. A UNICEF report on early marriage found that approximately 25% of Kenyan women aged 20-24 were married by the time they turned 18, and more than half of those women entered into polygamous marriages.[75] A 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%).[76] 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.[77] Additionally, husbands of married girls were three times more likely to be HIV-positive than sexual partners of unmarried girls.[78]

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,[79] the Marriage Act provides that either party could be below 18, provided that the consent of the lawful custodian is obtained [80] while the Hindu Marriage and Divorce Act[81] specifies 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.[82] 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.[83] In its 2007 Concluding Observations, the CEDAW Committee recommended that Kenya "harmonize civil, religious and customary law with article 16 of the Convention and to complete its law reform in the area of marriage and family relations in order to bring its legislative framework into compliance with articles 15 and 16 of the Convention, [and] to effectively enforce the Children's Act prohibiting child marriages [and] implement measures aimed at eliminating polygamy, as called for in the Committee's general recommendation No. 21."[84] In its seventh periodic report, the government notes that the Marriage Bill of 2007 consolidates all marriage laws including statutory, religious and customary laws, but the bill is yet to be passed into law.[85]

B. SEXUAL VIOLENCE

While sexual violence is widely under-reported, making it difficult to gather fully comprehensive statistics on its prevalence, figures indicate that it is a serious blight on the lives of Kenyan women. In 2009, a non-governmental organization, Men for Gender Equality Now, compiled data on rape from various sources, including police records, and found that about 16,400 rape cases are reported every year.[86] It also found that police reports show that "sexual assault cases constitute 50 per cent of offences reported to the force." [87] As of 2006, hospital statistics had indicated that approximately 16,500 cases of rape occurred each year.[88] While age-specific data is not collected by either the police or hospitals, the Child Rights Advisory Documentation and Legal Centre (CRADLE), a children's welfare non-governmental organization, says that most victims are under the age of 16 with the most vulnerable being between the ages of 9-16.[89]

Sexual violence also occurs in marital and intimate partner relationships. A 2008 United States Agency for International Development (USAID) study determined that Kenya has one of the highest rates of sexual violence between intimate partners of the ten countries surveyed, at 15%.[90] The data also exposed a significant link between intimate partner violence and unintended pregnancies.[91] The study further showed that, in Kenya, a slightly higher percentage of abortions are procured by women who have experienced intimate partner violence than by those who have not.[92] In addition, a study in Nairobi indicated that 4% of all HIV infections in adolescents are as a result of rape.[93]

Although some progress has been made in the legislative and law enforcement framework, such as the enactment of the Sexual Offences Act of 2006, which is an improvement over earlier piecemeal and inadequate laws on sexual violence, there are also serious shortcomings in the 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.[94] 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.

In addition, while the National Guidelines for the Medical Management of Rape/Sexual Violence, issued by the Division of Reproductive Health in the Ministry of Health and now in its second edition, outline the importance of providing counseling, emergency contraception, and post-exposure prophylaxis for victims of sexual violence as well as the importance of properly gathering evidence that can be used in prosecution,[95] it appears that the guidelines are not widely disseminated or known.[96] Many women who survive violence never receive EC.[97] Although sexual violence—rape and gang rape—was rampant during Kenya's post-election violence in 2007-2008, the Commission of Inquiry into Post-Election Violence found that many of the women were unable to receive "comprehensive services" normally offered to survivors of sexual violence because they came to the hospital more than 72 hours after the incident, due to the lack of security and transportation.[98] In addition to the physical and economic inaccessibility of healthcare services, women face stigma and fears of further violence or abandonment should others discover they experienced sexual violence.[99]

C. SEXUAL VIOLENCE IN SCHOOLS

Sexual violence is also prevalent in schools throughout Kenya but very little is being done to address the problem. In addition to the immense emotional and psychological impact, girls who have been raped face the additional possibility of becoming pregnant or acquiring an STI. Pregnant adolescents can be forced out of school and into early marriages or, as mentioned earlier, unplanned and unwanted pregnancies can lead to illegal, unsafe abortions. Sexual abuse by a teacher or school official can also lead to reluctance on the survivor's part to return to school or to excel in classes out of fear of being noticed by her abuser.[100] 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.[101]

One study suggests that nearly 60% of school-aged children have faced sexual harassment.[102] A recent study by the Center for the Study of Adolescence reported that at least one in twenty high school boys coerced girls into sex.[103] The same proportion of boys indicated that they had impregnated a girl. Sexual abuse is also perpetrated against female students by their teachers.[104] A 2009 report by the Teachers Service Commission (TSC) and the Centre for Rights Education and Awareness estimated that 12,660 Kenyan schoolgirls were sexually abused by their teachers between 2003 and 2007.[105] They further note that this is likely a gross underestimation of the prevalence of abuse since 90 percent of cases of abuse do not even reach the TSC.[106]

The failure to address and rectify these violations of rights has been characterized as a form of "violence by omission," which increases the victim's vulnerability to violence.[107] While the abuses often rise to the level of criminal conduct, the repercussion felt by the offending teacher is usually administrative, such as interdiction or suspension[108]or a transfer.[109] Inadequate administrative follow-up often results in the offending teacher's reinstatement leading to continued abuse of schoolchildren, while poor investigations and prosecutions lead to a less than 10% conviction rate of cases which go to court.[110] In April 2010, the TSC issued a Circular on Sexual Abuse expressing concern over "increasing cases of violence (physical, psychological and sexual) against pupils/students and recogniz[ing] that it is a violation of their human rights wherever it occurs."[111] However, the Circular does not specify what penalties beyond "disciplinary action" will be incurred.

D. DISCRIMINATION AGAINST PREGNANT SCHOOL GIRLS

Article 10 of CEDAW protects the rights of women and girls to an education and obligates states to reduce "female student drop-out rates and the organization of programmes for girls and women who have left school prematurely."[112] The Children's Rights Committee has expressed concern about the high rates of pregnancy among adolescents and the "difficulties pregnant girls face in order to continue their education."[113] In its seventh periodic report, the Kenyan government acknowledges that the increased completion of secondary school by Kenyan girls can be achieved only if obstacles to completion – such as unwanted pregnancies – are removed and policies to facilitate re-enrollment are implemented.[114] Yet, pregnant Kenyan school girls continue to face discrimination in schools, contributing to high drop-out rates and low retention rates.[115] Furthermore, there is a stark lack of equality between girls and boys in the rate of transition from primary to secondary schools.[116] 13,000 Kenyan girls leave school every year due to pregnancy,[117] constituting nearly one-third of the population of girls who drop out annually. Pregnancy and marriage have been called the greatest threats to the education of girls in Kenya.[118]

Although the Kenyan government has addressed discrimination against pregnant school girls in several policies, including the Education Act, the 2003 Gender and Education Policy and the 2009 National School Health Policy, the measures taken have been inadequate and sometimes counterproductive. For example, the 2009 National School Health Policy seeks to address adolescent pregnancy by imposing "voluntary" pregnancy tests on female students.[119] The policy states that "[g]irls will undergo voluntary medical screening once per term."[120] These tests will be imposed throughout a student's academic career. However, advocates have raised serious concerns that in an environment where schools and teachers have "absolute power" over their students, condoning voluntary testing may be taken as endorsement of mandatory pregnancy testing.[121]

Furthermore, officials of the Ministries of Health and Education have also expressed uncertainty as to the understanding of the term "voluntary."[122] One Health Ministry official said it would be evident that those girls who do not volunteer are most likely pregnant,[123] thereby exposing them to further stigma and discrimination. A Ministry of Education official suggests that the test is *not* voluntary for school girls, but rather that school administrators have discretion on how the policy should be implemented.[124] These officials confirm that the policy gives administrators discretion to test girls upon "suspicion" of being pregnant.[125] It is well documented that upon discovery of being pregnant, girls are often expelled from school.[126] Likewise, the Chief of Health at UNICEF Kenya cautioned that "gaps in implementation" of this policy could lead to violations of girl's rights to privacy and security of the person.[127]

Despite these observations, by December 2009, the Ministries had yet to decide "whether parents would be able to opt out of the test on their daughters' behalf or whether the decision would be entirely up to the student."[128] The Kenya National Association of Parents has noted that sex education in schools, rather than pregnancy testing, is the appropriate avenue for decreasing teen pregnancy.[129] Most recently, Kenya introduced the "Return to School" policy to enable young women and girls who get pregnant to return to school after delivery.[130] However, the implementation of this policy has been hampered by a lack of awareness of the policy; many schools, administrators, teachers, students and parents do not realize that it even exists.[131] This problem is compounded by the fact that academic institutions face no penalties for non-compliance with the policy.[132] There are also no official guidelines or sufficient legal backing for the implementation of the policy.[133] The policy also faces staunch opposition from those who "argue that allowing these teenage mothers back to school would trigger [a] multiplier effect among other girls."[134] Finally, stigma and

discrimination, in conjunction with poverty, are powerful barriers which prevent young mothers from returning to school.[135]

Pregnant school girls are often placed in an impossible situation. They experience discrimination and harassment whether they continue or terminate the pregnancy. Procuring an abortion can also mean risking being forced out of school due to harassment from teachers and students or expulsion.[136] However, school girls in Kenya may feel compelled to obtain an unsafe abortion, as a means of continuing their education. This dilemma is validated by experts at the World Bank who have suggested "that high unsafe abortion rates may be partially attributable to the continued extra-official expulsion of pregnant students from Kenyan schools."[137]

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

1. Kenya's new Constitution guarantees the right to "the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care." How does the government plan to make this right a reality? If legislation is part of the measures that the government intends to take, when will this comprehensive legislation be introduced?

2. 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 healthcare facilities are adequately equipped to provide quality, hygienic maternal healthcare services and provide respectful, quality care?

3. What efforts are being made to ensure that essential healthcare services, such as delivery services, are accessible to all women without cost? What steps has the government taken or does the government plan to take to ensure that all healthcare services that are intended to be free of charge do not incur user fees in practice? What steps are being taken to end the ongoing practice of detaining women in healthcare facilities, after giving birth, because of their inability to pay their medical bills?

4. Is the government planning to allocate more resources to the health sector and enhance the national health insurance scheme to make it accessible to all and not limited to only those in formal employment? How is the proposed National Health Insurance Fund bill going to address women's access to reproductive healthcare in terms of access to the services?

5. 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?

6. What steps are being taken to make access to contraceptives, emergency contraception and HIV 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?

7. What measures will Kenya take to ensure women's access to safe abortion services under the new Constitution and to safeguard the lives of women and girls from unsafe abortion, one of

the primary causes of maternal mortality? How does the government plan to address the lack of clarity surrounding the abortion law—how will it ensure that women and healthcare providers are aware that, under the new Constitution, abortion is permitted in cases where the life or health of the woman is in danger?

8. What governmental efforts exist to ensure post-abortion care for complications as well as reproductive health counseling? What measures are being taken to ensure that women who develop complications are not doubly victimized by both the healthcare and the criminal justice systems?

9. How does the government propose to improve training of healthcare 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? What steps are being taken to protect women and girls from gender-based violence and abuse in healthcare facilities? How does the government propose to ensure that women are able to report and seek redress for such abuses?

10. What measures has the government put in place to prioritize and adequately address the high incidence sexual violence in schools and discrimination against pregnant school girls?

We hope that the Committee will consider making the following recommendations to the government of Kenya:

1. With the new Constitution defining discrimination in line with CEDAW and providing stronger guarantees for women's rights, the state should prioritise and focus on ensuring enabling statutory and policy framework that promotes the implementation of the rights in the new Constitution. The Constitution also obligates the Government to domesticate and enforce treaties and conventions which Kenya has ratified; the state should take measures to implement these provisions through enacting legislation to fulfill its international obligations on human rights.

2. The state should enact a legal and policy framework for minimum state provision of primary health care, allocate more resources to the health sector and enhance the national health insurance scheme to make it accessible to all and not limited to only those in formal employment. The state should ensure that public hospitals that waive out-of-pocket costs for people who cannot meet their medical costs do not absorb all of the costs. This would ensure that healthcare providers do not continue to find the waiver process burdensome, making them reluctant to inform patients about it.

3. The government should comply with the CEDAW Committee's recommendation in 2007 to ensure that health workers adopt a client-friendly attitude that will lead to improved access to quality health care. It could so by taking concrete steps to immediately end the ongoing practice of detaining patients who are unable to pay their medical bill, which occurs in both public and private facilities.

4. The government should demonstrate its commitment to reducing maternal mortality and morbidity by increasing the number of healthcare facilities that are fully equipped to provide comprehensive maternal healthcare.

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

6. The state should make concerted efforts to ensure an adequate and consistent supply of contraceptives, including emergency contraception, to address the prevalence of stock-outs; monitor providers to prevent the practice of charging formal and informal user fees even when contraceptives should be free; and initiate campaigns to tackle the stigma and discrimination faced by women and adolescents trying to access contraceptives.

7. Kenya should comply with the CEDAW Committee's recommendation that sex education be widely promoted and targeted at adolescents, with special attention to the prevention of early pregnancy and the control of sexually transmitted infections. It could do so by addressing concerns raised by the Ministry of Health regarding the inadequate content of sexual education curriculum in schools, which has contributed to the inability of adolescents to prevent unwanted pregnancies.

8. Kenya should pass into law the 2007 Marriage Bill, which consolidates all marriage laws including statutory, religious and customary laws, and sets the minimum legal age of marriage at 18 years, in order to reduce the risks early marriage can pose to girls.

9. It should also amend the 2006 Sexual Offences Act to include marital rape as a punishable offence and remove the provision which states that persons who falsely allege a sexual offence are guilty of an offence since this could discourage legitimate victims who fear that poor police investigation may result in claims that they falsely accused the perpetrators.

10. The state should urgently investigate, prosecute, and punish sexual violence perpetrated by male teachers and students against female students, which is prevalent in schools throughout Kenya, but is grossly underreported because of fears of social stigma, negative repercussions at school, and mishandling by investigating agencies.

11. The state should take immediate steps to address discrimination against pregnant school girls and ensure that policies developed in this regard are not counter-productive, such as involuntary pregnancy testing which exposes girls to further stigma, expulsion and unsafe abortion.

12. The state should increase awareness about its "Return to School" policy for girls who get pregnant and develop official guidelines for its implementation to ensure that schools, students, and parents know of its existence. It should institute and enforce penalties when schools fail to comply with the policy.

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

Sincerely,

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[1] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, art. 12, para. 2, G.A. Res. 34/189, UN GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

[2] NATIONAL BUREAU OF STATISTICS [KENYA], 2008-2009 KENYA DEMOGRAPHIC AND HEALTH SURVEY 114 (2010), *available at* http://www.measuredhs.com/pubs/pdf/FR229/FR229.pdf [hereinafter KDHS 2008-2009]. According to the 2008-2009 KDHS, 36.1% of women who attained more than secondary school education receive antenatal care from a medical doctor compared to 21% of women with no education; 40.5% of women in the urban areas are likely to receive the same care from a doctor compared to 25.9% of women in the rural areas; and 39.2% of those in the highest wealth percentile received antenatal care from a doctor, compared to 19.9% of those in the lowest wealth percentile. Similar disparities exist in these groups' ability to access antenatal care from a nurse or midwife.

[3] Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Kenya*, paras. 37-38, U.N. Doc. CEDAW/C/KEN/CO/6 (Aug. 10, 2007).

[4] Government of Kenya, *Consideration of reports submitted by States parties under article 18 of CEDAW: Seventh periodic reports of States parties: Kenya*, para. 207, U.N. Doc. CEDAW/C/Ken/7 (Nov. 10, 2009) [hereinafter Kenya Government Report].

[5] Margaret Perkins et al., *Out-of-pocket costs for facility-based maternity care in three African countries*, 24 Health Policy and Planning, 289, 296 (2009).

[6] *Id.* at 297.

[7] Committee on the Rights of the Child, *Concluding Observations: Kenya*, paras. 48, 52, U.N. Doc. CRC/C/KEN/CO/2 (Jun. 19, 2007) [hereinafter CRC 2007 *Concluding Observations: Kenya*].

[8] 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) .

[9] CENTER FOR REPRO. RIGHTS & FIDA KENYA, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES at 53 (2007) [hereinafter FAILURE TO DELIVER].

[10] *Id.* at 56-58.

[11] 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).

[12] KDHS 2008-2009, *supra* note 2, at 272.

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

[14] CEDAW Committee, *General Recommendation 24: Women and health*, (20th Sess., para 27, U.N. Doc. A/54/38 (1999).

[15] *Id.*

[16] 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.
[17] Kenya Government Report, *supra* note 4, at 180.
[18] KDHS 2008-2009, *supra* note 2, at 273.
[19] WORLD HEALTH ORGANIZATION, MATERNAL MORTALITY IN 2005 25 (2007), http://www.who.int/whosis/mme_2005.pdf.
[20] Kenya Government Report, *supra* note 4, at 203.
[21] NATIONAL CO-ORDINATING AGENCY FOR POPULATION AND DEVELOPMENT, THE MINISTRY OF HEALTH, AND THE CENTRAL BUREAU OF STATISTICS, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2004 128-140 (2005) [hereinafter KSPAS 2004].
[22] *Id.* at 135. Items for infection control include hand washing supplies, clean or sterile gloves, disinfecting solution and a sharps box. *Id.* at 131.
[23] FAILURE TO DELIVER, *supra* note 9; KSPAS 2004, *supra* note 21, at 128-140; KDHS 2008-2009, *supra* note 2.
[24] FAILURE TO DELIVER, *supra* note 9, at 26-40.
[25] *Id.*
[26] CEDAW Committee, *Concluding Observations:* Kenya, para. 38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).
[27] MINISTRY OF HEALTH (KENYA), KENYA NATIONAL POST ABORTION CARE CURRICULUM: TRAINER'S MANUAL 26 (2003), *cited in* CENTER FOR REPRO. RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 25 (2010) [hereinafter IN HARM'S WAY].
[28] WORLD HEALTH ORGANIZATION, MATERNAL MORTALITY IN 2005: estimates developed by WHO, UNICEF, UNFPA, & THE WORLD BANK 25 (2007) *available at* http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf , *cited in* IN HARM'S WAY, *supra* note 27, at 25.
[29] MINISTRY OF HEALTH [KENYA], A NATIONAL ASSESSMENT OF THE MAGNITUDE AND CONSEQUENCES OF UNSAFE ABORTION IN KENYA 21 (2004).
[30] *Id.*
[31] Hailemichael Gebreselassie, *The magnitude of abortion complications in Kenya*, 112 BJOG: AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY 1229 (Sept. 2005), *cited in* IN HARM'S WAY, *supra* note 27, at 26.
[32] In Harm's Way, *supra* note 27, at 25-26; Kenya Government Report, *supra* note 4.
[33] The Penal Code, (Rev. Ed. 2009), Laws of Kenya Cap. 63 Sec. 240 [hereinafter The Penal Code]. The Ministry of Health, in its guidelines on the care of survivors of rape and sexual violence, has indicated that abortion "may be allowed" 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, 2ND EDITION 13 (2010) [hereinafter MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE].
[34] IN HARM'S WAY, *supra* note 27, at 13.
[35] *Id.* at 13.
[36] Constitution, Art. 26(4) (2010) (Kenya).
[37] The Penal Code, *supra* note 33, Sec. 240. MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE, *supra* note 33, 2nd ED. at 13.
[38] Constitution, Art. 26(4) (2010) (Kenya).
[39] *Id.* Art. 26(2).
[40] IN HARM'S WAY, *supra* note 27, at 14.
[41] *Id.* at 15.
[42] *Id.* at 88.
[43] *Id.* at 15.
[44] CEDAW Committee, *General Recommendation No. 19: Violence against women*, para. 24(m), U.N. Doc A/47/38 (Jan. 29, 1992) [hereinafter CEDAW *General Recommendation No. 19*].
[45] See, e.g., CEDAW Committee, *Concluding Observations*: Brazil, paras. 29-30, U.N. Doc. CEDAW/C/BRA/6 (2007); Chile, para. 20, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); Honduras, para. 25, U.N. Doc. CEDAW/C/HON/CO/6 (2007); Mauritius, para. 31, CEDAW/C/MAR/CO/5 (2006); Nicaragua, para. 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); Pakistan, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007); Peru, para. 482, U.N. Doc. A/57/38 (2002); Philippines, para. 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).

[46] Human Rights Committee, *Concluding Observations*: *Kenya*, para. 14, U.N. Doc. CCPR/CO/83/KEN (Apr. 29, 2005); CRC 2007 Concluding Observations: Kenya, *supra* note 7, para. 49.
[47] 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.
[48] IN HARM'S WAY, *supra* note 27, at 44.
[49] Joyce Mulama, *Contraceptives: Stock-outs Threaten Family Planning*, Inter Press Service (Latin America), May 18, 2009; *see also* KSPAS 2004, *supra* note 21, at 5, *cited in* IN HARM'S WAY, *supra* note 27, at 44-45.
[50] Mulama, *supra* note 49, *cited in* IN HARM'S WAY, *supra* note 27, at 45.
[51] KSPAS 2004, *supra* note 21, *cited in* IN HARM'S WAY, *supra* note 27, at 45.
[52] IN HARM'S WAY, *supra* note 27, at 44-45.
[53] Susan Anyangu, *Practical Measures Needed on Teen Sexual Education*, Inter Press Service, Oct. 27, 2009, *available at* http://allafrica.com/stories/200910271243.html (last visited Feb. 4, 2010); IN HARM'S WAY, *supra* note 27, at 46.
[54] 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/.
[55] GUTTMACHER INSTITUTE, FACTS ON ABORTION IN KENYA 1 (2009), *available at* http://www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] KDHS 2008-2009, *supra* note 2, at 99.
[60] *Id.* at 100.
[61] *Id.* at 61.
[62] IN HARM'S WAY, *supra* note 27, at 47.
[63] IN HARM'S WAY, *supra* note 27, at 47; *see* Jill Keesbury et al., *Mainstreaming Emergency Contraception (EC) in Kenya: Final Project Report* 29 (Population Council, Nairobi, 2009).
[64] Keesbury, *supra* note 63, at 12.
[65] IN HARM'S WAY, *supra* note 27, at 47-48.
[66] *Id.*
[67] DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH [KENYA], ADOLESCENT REPRODUCTIVE HEALTH AND DEVELOPMENT POLICY: PLAN OF ACTION 2005-2015 2-3 (2005).
[68] IN HARM'S WAY, *supra* note 27, at 48.
[69] Sammy Cheboi, *Sex Education Lacking, Says Health Official*, The DAILY NATION, Sept. 23, 2009, *available at* http://allafrica.com/stories/200909230822.html, *cited in* IN HARM'S WAY, *supra* note 27, at 48.
[70] CEDAW Committee, *Concluding Observations:* Kenya, para. 38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).
[71] KDHS 2008-2009, *supra* note 2, at 55.
[72] *Id.* at 55, 56.
[73] CEDAW, *supra* note 1, 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.").
[74] CEDAW General Recommendation No. 19, *supra* note 44, at paras. 4, 6.
[75] UNICEF, EARLY MARRIAGE: A HARMFUL TRADITIONAL PRACTICE 32 (2005).
[76] Shelley Clark, *Early Marriage and HIV Risks in Sub-Saharan Africa*, 35 STUD. FAM. PLAN. 149, 150 (2004).
[77] *Id.* at 149.
[78] *Id.*
[79] 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.
[80] The Marriage Act, (Rev. Ed. 2008) Cap. 150 Arts. 11(1)(b); 19 (Kenya). Note that Art. 35 (2) provides that a marriage is void if either party is below 16.
[81] The Hindu Marriage and Divorce Act, (Rev. Ed. 2008) Cap 157 Art. 3(c) (Kenya).

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[83] CRC 2007 Concluding Observations: Kenya, *supra* note 7, paras. 22, 53-54.
[84] CEDAW Committee, *Concluding Observations:* Kenya, para. 44, U.N. Doc. CEDAW/C/KEN/CO/6 (2007).
[85] Kenya Government Report, *supra* note 4, at para.76. Sec. 8 of the Marriage Bill states that "[n]o person shall marry while under the age of eighteen years." The Marriage Bill, (2007) Sec. 8 (Kenya), *available at* http://www.kenyalaw.org/Downloads/Bills/Unpublished/200703.pdf.
[86] Renson Mnyamwezi, *NGO decries rise in rape cases*, The Standard, April 23, 2009, at 9, *cited in* IN HARM'S WAY, *supra* note 27, at 42.
[87] *Id.*
[88] Mercy Randa, *Sexual Abuse Cases on Children Up*, NATION (NAIROBI), June 16, 2006.
[89] *Id.*
[90] Michelle J. Hinden et al., *Intimate Partner Violence Among Couples in 10 DHS Countries: Predictors and Health Outcomes* xi (United States Agency for International Development, 2008), *cited in* IN HARM'S WAY, *supra* note 27 at 42.
[91] *Id.* at 63.
[92] *Id.* at 62, tbl. 4.2.
[93] 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).
[94] The Sexual Offences Act, (2006) Sec. 38 (Kenya).
[95] MEDICAL MANAGEMENT OF RAPE/SEXUAL VIOLENCE, *supra* note 33, Ed. 1& 2.
[96] In Harm's Way, *supra* note 27, at 34.
[97] *Id.* at 43.
[98] COMMISSION OF INQUIRY INTO THE POST ELECTION VIOLENCE, FINAL REPORT (CIPEV) 247-248 (2008) *available at* http://www.communication.go.ke/Documents/CIPEV_FINAL_REPORT.pdf, *cited in* IN HARM'S WAY, *supra* note 27, at 43.
[99] IN HARM'S WAY, *supra* note 27, at 43, 44.
[100] HUMAN RIGHTS WATCH, SCARED AT SCHOOL: SEXUAL VIOLENCE AGAINST GIRLS IN SOUTH AFRICAN SCHOOLS 61 (2001).
[101] *Id*.
[102] Sara Jerop Ruto, *Sexual Abuse of School Age Children: Evidence from Kenya*, 12 J. OF INT'L COOP. IN EDUC. No.1 177, 180 (2009).
[103] Joy Wanja, *Teenage Sex Study Shock for Parents*, DAILY NATION, Oct. 13, 2009, *cited in* IN HARM'S WAY, *supra* note 27, at 42.
[104] Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION, Nov. 1, 2009 *available at* http://allafrica.com/stories/200911020402.html, *cited in* IN HARM'S WAY, *supra* note 27, at 42.
[105] *Id*.
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[107] Fatuma Chege, *Education and Empowerment of Girls against Gender-based Violence*, 10 J. OF INT'L COOP. IN EDUC. No.1 53, 61 (2006).
[108] KENYA ALLIANCE FOR ADVANCEMENT OF CHILDREN, ET. AL., STATE VIOLENCE IN KENYA: AN ALTERNATIVE REPORT TO THE UNITED NATIONS HUMAN RIGHTS COMMITTEE 104 (2005).
[109] Daniel Wesangula, *New School Guidelines to Protect Students Against Sex Pest Teachers*, DAILY NATION, May 1, 2010, *available at* http://allafrica.com/stories/201005030679.html.
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[111] Teacher's Service Commission Kenya, Circular No. 3/2010 (Apr. 29, 2010) *available at* http://www.tsc.go.ke/CIRCULAR%20%20ON%20SEXUAL%20ABUSE.pdf.
[112] CEDAW, *supra* note 1, Art. 10(f).
[113] CRC 2007 *Concluding Observations: Kenya*, *supra* note 7, at 49.
[114] Kenya Government Report, *supra* note 4, at 148.
[115] CENTRE FOR THE STUDY OF ADOLESCENCE, DOWN THE DRAIN: COUNTING THE COSTS OF TEENAGE PREGNANCY AND SCHOOL DROP OUT IN KENYA 8, 29 (2008), *available at* http://www.csakenya.org/pdfs/CSA%20Pregnancy-FINAL%202-EDITED.pdf [hereinafter DOWN THE DRAIN].
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[120] *Id*.
[121] *Id*.
[122] *Id*.
[123] *Id*.
[124] *Id*.
[125] *Id*. Suspicious signs include "girls sleeping in class, being choosy about food or vomiting."
[126] IN HARM'S WAY, *supra* note 27 at 53.
[127] Vukets, *supra* note 117.
[128] *Id*.
[129] *Id*.
[130] DOWN THE DRAIN, *supra* note 115, at 42.
[131] Oyaro, *supra* note 117.
[132] DOWN THE DRAIN, *supra* note 115, at 8.
[133] *Id*. at 42.
[134] Oyaro, *supra* note 117.
[135] DOWN THE DRAIN, *supra* note 115, at 8.
[136] IN HARM'S WAY, *supra* note 27, at 56.
[137] Ellen M. H. Mitchell et al., *Social scripts and stark realities: Kenyan adolescents' abortion discourse*, 8(6) Culture, Health and Sexuality 515, 518 (Dec. 2006), *cited in* IN HARM'S WAY, *supra* note 27, at 55.