Committee on the Rights of the Child
Human Rights Treaties Division
Office of the United Nations High Commissioner for Human Rights
Palais Wilson - 52, rue des Pâquis
CH-1201 Geneva, Switzerland

December 15, 2015

Re: Supplementary information on the List of Issues for Kenya scheduled for review by the Committee on the Rights of the Child during its 71st Session

Dear Committee Members:

The Center for Reproductive Rights (the Center), a global legal advocacy organization with headquarters in New York, and regional offices in Nairobi, Bogota, Kathmandu, Geneva, and Washington D.C., submits this letter to provide responses to and recommendations on some of the questions in the List of Issues (LOIs) developed by the Committee on the Rights of the Child (the Committee) during its pre-session review of Kenya. This letter focuses on the questions that reflect the concerns raised in a letter the Center submitted for the pre-session review of Kenya. The pre-session letter also contains a list of questions we hope the Committee will consider using during its review of Kenya. We have annexed the pre-session letter for further reference.

I. The Right to Sexual and Reproductive Health Services and Information

In response to the LOIs in which the Committee asked the state to **"elaborate more on the sexual and reproductive health information and services that are available to adolescents,"**[1] the state outlined some initiatives it has undertaken. This includes the adoption of the Adolescent Sexual and Reproductive Health Policy; development of the Education Sector Policy on HIV and AIDS; establishment of youth friendly centers that offer sexual reproductive health information; provision of life skills classes in schools; and the signing of the commitment to "promote comprehensive sexuality education and sexual and reproductive health services for adolescents and young people."[2] However, even though the Committee asked for **updated statistical data on "the number of adolescent girls who have access to information, services and care relating to sexual and reproductive health, including access to contraceptives,"** the government admitted to the unavailability of this information but that the aforementioned efforts are being undertaken "to ensure that the services are availed to as many adolescent boys and girls as possible." Yet,

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despite these efforts, the following sections demonstrate that adolescents in Kenya still lack access to comprehensive sexual and reproductive health services.

A) Lack of access to contraceptive information and services

According to the 2014 Kenya Demographic and Health Survey (2014 KDHS), only about half of Kenyan women (53.4%) are able to access modern methods of contraceptives,[3] an increase of only seven percentage points from the 2008 rate.[4] Moreover, the rate remains startlingly low for adolescents as the use of modern contraceptives for those aged 15 to 19 who are married or unmarried but sexually active is only 36.8%.[5] The 2014 KDHS also reflects the fact that 23% of married girls aged 15- 19 have an unmet need for contraceptives.[6]

This low rate of contraceptive usage is largely due to the barriers to girls' access. Many public health facilities face a profound shortage of contraceptives.[7] In many cases, preferred methods of contraception may be unavailable.[8] Financial barriers further prevent access to contraceptives. Despite the Ministry of Health's policy that contraceptives should be available free of charge, many government health facilities charge their patients "user fees" for family planning services and some charge for the contraceptive method itself.[9] Community and familial attitudes and opinions towards contraception also restrict contraceptive access.[10] This is particularly problematic for adolescents, as most face stigma and discrimination if they attempt to access family planning services.[11] For example, girls who carry condoms are perceived as promiscuous, "sexually wayward," or "untrustworthy"; and those who are unmarried feel ashamed to obtain contraceptives.[12] In the Center's fact-finding report, one young woman recounted being turned away when she attempted to get an intrauterine device. "[T]hey said no at the government facility. They said you are a Muslim girl, you are going to burn in hell. She was a Muslim nurse and refused to give me contraceptives."[13] Adolescents in Kenya also lack formal and comprehensive sex education,[14] resulting in misinformation about their reproductive health, including concerns about poor outcomes from using contraceptives.[15] These misconceptions lead to lower contraceptive use rates and a higher incidence of unplanned and unwanted pregnancies.[16]

In addition, adolescent girls in Kenya encounter significant barriers in accessing Emergency Contraceptive (EC)—a safe and effective method that can be used within 120 hours of unprotected sex and a critical component of care for survivors of sexual violence.[17] Consistent stock outs in pharmacies and shipment delays prevent girls from reliably accessing the medicine.[18] Some pharmacists also decline to distribute EC altogether or refuse to dispense it without a prescription,[19] although EC is registered in Kenya as an over-the-counter medicine.[20] Despite the Ministry of Health's guidelines that explicitly permit EC's usage for any unprotected sex, arbitrary refusals stem from the perception that the contraceptive is only intended to be used by rape victims.[21] Moreover, adolescents are routinely denied access to EC for arbitrary or discriminatory reasons such as "the person look[ed] young."[22] A 2014 study found out that only 18% of women and girls surveyed in Nairobi have ever used EC.[23] Private health care facilities may not always offer EC either. For example, although facilities run by the Catholic Church or Christian Health Association of Kenya provide services to survivors of sexual violence, they do not provide EC to these individuals.[24] Access to EC is an essential component of the full range of contraceptive options that adolescent girls must have—particularly for survivors of sexual assault and following unprotected sex—in order to ensure their right to reproductive autonomy.[25]

B) Lack of access to maternal health care

Due to this lack of access to reproductive health information and services, 18% of girls aged 15-19 have either given birth or are pregnant by the age 19.[26] This is particularly concerning since

teen pregnancy in Kenya is a major contributor to the overall maternal mortality, [27] which remains alarmingly high. The WHO reports that Kenya's maternal mortality rate (MMR) has only decreased by 0.8% per year since 1990—well short of the target rate of 5.5%—which has left Kenya far off track in achieving its Millennium Development Goal target MMR of 175 deaths per 100,000 live births by 2015.[28] Currently, according to the same report, 400 Kenyan women and girls die per every 100,000 live births.[29] In some low-income urban areas, the estimated MMR is as high as 706 deaths per 100,000 births.[30] Although the current MMR has shown some improvement from the 2008-2009 rate, it has not reduced significantly from the rate in 2003.

Apart from a disproportionate risk of death during and after child birth,[31] adolescent girls are also vulnerable to pregnancy-related complications.[32] However, adolescents in Kenya often lack access to ante-natal, delivery and post-natal care, maternal health care services that are essential to preventing maternal mortality and morbidity. According to the 2014 KDHS, although 94% of those below the age of 20 who have given birth reported at least one antenatal care visit,[33] only 48.9% attended the WHO recommended four or more antenatal care visits.[34] Moreover, geographic location has a significant impact on women and adolescent girls' access to antenatal care: for example, 68% of those living in urban areas are more likely to attend four or more antenatal care visits compared to 51% of those living in rural areas.[35]

Adolescent girls also face challenges in obtaining quality delivery care; the 2014 KDHS notes that only about 62% of those below the age of 20 obtained delivery assistance from a skilled provider such as a doctor, nurse, or midwife.[36] Further, while the WHO recommends postnatal care starting an hour after giving birth for the first 24 hours in order to check for complications,[37] only 51% receive a postnatal checkup within two days of giving birth.[38]

In recent years, the Kenyan government has made some efforts to address these issues. For example, in June 2013, the Kenyan government issued a Presidential Directive which provided that all pregnant women would be able to, "access free maternity services in all public health facilities."[39] Nevertheless, as described below, implementation of this Presidential Directive remains a challenge. In addition, in January 2014, the First Lady of Kenya spearheaded the Beyond Zero Campaign to raise awareness about the link between good health and a strong nation, specifically demonstrating the importance of maternal, newborn, and children's health.[40] The Campaign has delivered thirty six mobile clinics since its inception.[41] However, as the First Lady has stated, "the initiative alone cannot bring about success. Success requires all actors in the health sector especially county governments to expand this program to every corner" of Kenya.[42] As such, the government needs to scale up its efforts to ensure all pregnant adolescent girls have access to comprehensive maternal health services.

Detention, abuse and neglect of women and adolescent girls seeking maternal health services in health care facilities

Those adolescent girls who manage to overcome the barriers to accessing maternal health services often encounter detention, neglect and abuse from health care professionals and staff while attending maternal health services.[43] As mentioned in the Center's submission to inform the Committee's pre-session review of Kenya (see Annex), the study conducted by the Center and the Federation of Women Lawyers-Kenya revealed the existence of serious delays and a lack of adequate medical care at maternal health care facilities.[44] The research also documented systematic abuses in administering reproductive health services, including physical and verbal abuse against those seeking services, such as rough treatment during labor.[45] Interviewees recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal

abuse from nurses if they expressed pain or fear.[46] The research further found delays in medical care during labor or while waiting for stitches after delivery, and instances of being stitched without anesthesia post-delivery causing many to endure excruciating pain.[47]

Particularly, interviewees noted that health care providers discriminated against young girls.[48] One interviewee described the treatment young girls receive at a public health facility saying: "There are young girls who are giving birth early, even at nine years. They labor and [the doctors and nurses] don't care. They abuse them and the child gets confused."[49] Another recounted: "The nurses came and started abusing me, saying, 'You young girl, what were you looking for in a man? Now you can't even give birth.'"[50] Another who gave birth while in secondary school recalled the neglect she experienced during delivery saying:[51]

> "I remember I was a kid and when I was asked to push I didn't know what to push. I pushed till I went for a long call [had a bowel movement]. The nurses left me and told me it's my problem."

In addition to the inhumane and abusive treatment pregnant adolescent girls face in maternal health care, the research also revealed that they are frequently denied maternity health care if they fail to pay the initial deposit for such services, both in private and in public health care facilities.[52] Even after admission to facilities, they may be denied essential and often life-saving treatment if they fail to pay their remaining balance.[53] And in many cases, those who are unable to pay the required fees for services rendered during their labor and delivery are detained at the health care facilities, often without post-natal care and basic necessities, such as bedding and food for themselves and their newborns.[54] Importantly, there is a lack of effective internal and external mechanisms for redress for these violations of their human rights.[55] Even when redress mechanisms are available, they are usually not known or the necessary information on how to access them may be lacking.[56] This particularly affects adolescents as they are less likely to have access to financial resources to pay the required fees and lack the capacity to demand redress for any violations.

In response to these egregious actions, the Center filed a case in the High Court of Kenya in 2012 highlighting this abuse and mistreatment at health care facilities and seeking declaration that this treatment amounts to a violation of their human rights.[57] One of the petitioners in this case was mistreated and treated inhumanly at Pumwani Maternity Hospital (PMH). Even though she was in labor and severely bleeding upon arrival, she did not receive immediate care and was not taken to the operating room until two hours after her arrival.[58] Although her bladder had ruptured during the caesarean section, she did not receive immediate care, subjecting her to pain and suffering.[59] Her suffering was compounded by the fact that her wound from the surgery was infected and the stitching had been poorly performed.[60] To make matters worse, during the days following her caesarean section, she was detained because she was unable to pay her hospital fees and was forced to sleep on a cold floor without any subsequent medical care.[61] Both petitioners in the case were made to sleep on the floor during their detention—one was even forced to sleep next to a toilet, which routinely flooded.[62] On September 17, 2015, the Court passed a decision and found that the rights of the two petitioners, including their right to health, liberty and dignity, had been violated by the actions of the health care professionals at PMH and that they were discriminated against based on their socio-economic status. The court also ordered the government to pay monetary compensation to the petitioners for the damages they suffered as a result of these violations. Accordingly, it is vital for the government to immediately comply with the recent judgment from the High Court that confirms the detentions are human rights violations, by ensuring the detentions do not continue. It should further ensure that those accessing maternal health services do not

encounter mistreatment and abuse by providing proper training to health care professionals and staff and creating a mechanism for redress should violations occur.

Inadequate Implementation of Presidential Directive on Free Maternity Care
As mentioned above, the government issued a Presidential Directive in June 2013, which provided that all pregnant women and adolescent girls would be able to "access free maternity services in all public health facilities."[63] However, the government's report fails to detail the steps that are being taken to ensure the effective implementation of this declaration despite various reports indicating that serious problems with implementation have resulted in significant barriers to accessing quality maternity services in practice. According to the Kenya National Commission on Human Rights (KNCHR), hospital infrastructure and staffing cannot support the increase in the number of those who come seeking free maternal health care due to this declaration,[64] and the government has failed to allocate sufficient additional resources to remedy this issue. [65] Furthermore, there have been no clear guidelines set by the government about how to implement the free maternal services. Although some facilities have reportedly been given extra money to cover the influx of deliveries, others have remained uncertain of how to balance the new policy of free care with their need to cover costs.[66] In fact, on October 21, 2015, Nairobi's County Governor, Dr. Evans Kidero, abolished free maternity care at the PMH, Kenya's largest public maternity hospital, due to the national government's failure to reimburse Nairobi for Sh165 million spent covering maternity services over the past nine months. [67] A number of other counties also complained that the national government was slow in distributing reimbursements for free maternity services.[68]

In addition, although the government has said that maternal health services would be free, in reality, not all costs associated with giving birth have been eliminated.[69] Those who attend the health care facilities still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.[70] Other key components of maternal health services, including antenatal and postnatal care, are also not covered under the directive.[71] Further, the Reproductive Healthcare Bill that was tabled in parliament provides for free antenatal care,[72] but does not cover postnatal care or provide any guidance regarding implementation of the Directive. As mentioned above, since adolescents often lack independent financial resources, the lack of implementation of the directive will have a disparate effect on them and therefore, might be a hindrance to access.

The declaration of free services has also not addressed the issue of abuse and mistreatment while seeking maternal health services; in fact, the situation may have worsened as health care staff attempt to cope with an influx of delivery patients. [73] The continued abuse following the Presidential Directive has been challenged in a recent case filed by the Center at the Bungoma High Court where the petitioner was neglected and abused by the hospital's staff. She was not monitored while in labor and, when she was unable to find a free bed in the delivery ward, she collapsed unconscious on the floor, where she gave birth without any assistance from medical staff. When she subsequently regained consciousness, two nurses were slapping her face and shouting at her for dirtying the hospital floor during delivery.[74]

C. Lack of Access to Safe Abortion Services and Post-Abortion Care

In the LOIs the Committee asked the state to **"elaborate on the sexual and reproductive health information and services that are available to adolescents and indicate whether adolescent girls can have access to safe abortion and post-abortion services."**[75] In response, the government stated that it had made safe abortion available in accordance with Article 26 of the

Constitution which provides: "Abortion is 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, or if permitted by any other written law."[76] The government further stated that it had "[m]ade Post Abortion Care available to all."[77]

Despite this response from the government, research shows that adolescents continue to resort to unsafe abortion due to the number of barriers they encounter in accessing safe abortion service. First, the laws governing abortion in Kenya are confusing and conflicting. While the Constitution allows abortion in the aforementioned circumstances, the penal code has not been revised to reflect this change.[78] Moreover, before its revision in 2014, the 2004 *National Guidelines on the Medical Management of Rape and Sexual Violence* provided that "[t]ermination of pregnancy is allowed in Kenya after rape" since it is allowed under the 2006 Sexual Offences Act.[79] Even though this statement was removed during the revision of the guideline in 2014, the new guideline still provides that survivors of sexual violence have the right to "[a]ccess termination of pregnancy and post-abortion care in the event of pregnancy from rape."[80] Yet neither the Constitution nor the Penal Code have expressly provided for this exception, and the government has not clarified whether this exception for rape applies under the 2010 Constitution. Further, although the proposed Reproductive Health Bill would codify the life and health exception from the Constitution, the Bill places unnecessary and likely unconstitutional restrictions on access under these circumstances. The Bill would require an adolescent to get the consent of parents or a guardian to get an abortion where her life or health is at risk,[81] which would violate her rights to life, health, and non-discrimination by putting her at heightened risk of dying due to the denials or delays in access to safe abortion care.

Second, the confusion was further compounded by recent actions of the Ministry of Health and Director of Medical Services. Following the 2010 Constitutional amendment, the Ministry of Health developed and approved the *"Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortions in Kenya"* (Standards and Guidelines), which clarified the circumstances in which medical professionals could perform safe abortion services.[82] However, this Standards and Guidelines was subsequently withdrawn under unclear circumstances, leaving health care workers without official guidance as to when abortions were legal.[83] Further, in 2013, the Director of Medical Services issued a memo to all health care workers saying that "[t]he Constitution of Kenya 2010 is clear that abortion on demand is illegal . . ." without clarifying the circumstances under which it is legal.[84] The memo further stated that it is illegal for health care workers to participate in trainings on either safe abortion care or the use of abortion drugs, and threatened health care workers who choose to take these trainings with legal and professional sanctions.[85] These threats against health care workers significantly limit access to safe abortion not only by incentivizing health care workers to avoid prosecution by turning away those seeking safe and legal abortion, but also by stymying health care workers' access to the medical information and professional skills needed to safely perform the procedure.

In June 2015, the Center filed a case in the High Court of Kenya at Nairobi that challenged the Ministry of Health's memo and the withdrawal of the Standards and Guidelines. The case was brought on behalf of four petitioners, including "Wanjiku," a 15-year-old girl who had an unsafe abortion after an older man coerced her into having sex. Feeling anguished and fearing rejection from her family, Wanjiku decided to end the pregnancy but found safe abortion services to be unavailable. She was forced to seek care from an unqualified individual who used a dangerous method and botched the procedure. Afterwards, she started to vomit, bleed heavily, and swell—

signs that her kidney was failing. She had to travel to Nairobi to get post-abortion care (PAC). However, when she could not afford to pay the medical bills for the PAC, she was detained by the hospital and forced to sleep on the floor. Doctors diagnosed Wanjiku with a kidney disease that requires regular dialysis, and ultimately a kidney transplant. She also had to drop out of school and to date, has not been able to return.

The government's failure to ensure access to safe and legal abortion, including for victims of sexual violence, and to address the existing legal uncertainties have sustained the high levels of unsafe abortion-related injuries and death in the country. Unsafe abortion, due to unsafe methods and unqualified providers, is prevalent,[86] and "as many as 60% of all gynecologic emergency hospital admissions are due to abortion complications."[87] In 2012, an estimated 119,912 women and girls experienced complications from induced abortions, approximately 40% of which were classified as moderate and 37% as severe.[88] An estimated 266 per 100,000 die from unsafe abortions, a rate almost nine times higher than in the developed world,[89] and unsafe abortions are estimated to cause 35–50% of all maternal deaths.[90] In August 2015, a major newspaper in Kenya reported multiple stories of those who experienced unsafe abortion services with grave consequences to their life and health.[91] One such story is that of Beatrice, a college student, who procured an unsafe abortion and suffered kidney failure and was paralyzed as a result.[92]

The lack of clarity about Kenya's abortion laws is particularly harmful to young[93] and low-income women, among whom the unintended pregnancy rate is highest.[94] As data from the Ministry of Health shows, 45% of women aged 19 and younger and 47% of students who sought post-abortion care experienced severe complications.[95] Even where relatively safe abortion procedures are available, the cost of these services generally exceeds the economic resources of those who need them.[96] Although the cost of safe abortions varies widely depending on the clinic and stage of pregnancy, it may range from approximately $13 to $132.[97] Conversely, herbalists and unqualified individuals may charge as little as $4.[98] With the average daily income of Kenyans amounting to only $2.50,[99] the price disparity between safe and unsafe abortion is a drastic one, particularly for adolescents and students who are likely not to have an income or earn less than the average income.

Post-abortion care (PAC)

Although the government, in its response to the LOIs, stated that PAC is available to all women, adolescent girls in Keya encounter various barriers to access. Reports by the KNCHR and the Center have revealed that those needing PAC often delay seeking the service due to fear of the social stigma and legal risks associated with the procedure, including harassment by the police and possible prosecution.[100] Although the government has stated that PAC "is legal and not punishable by any part of Kenya laws,"[101] this declaration only offers protection to the health care providers and not to those seeking the service.[102] Further, delays in arriving at the health care facility and obtaining the right treatment are endemic in Kenya as a result of "shortages in staffing, equipment, drugs, and poor attitude of health care providers."[103] These delays can have fatal consequences for those who present with treatable conditions.[104]

Furthermore, medical providers may exacerbate the barriers in accessing PAC. Studies indicate that since most medical personnel—particularly nurses—are not adequately trained, patients suffering from complications may have to wait an extended period of time for a trained provider to attend to their medical needs.[105] Medical providers may also make them feel like criminals instead of patients by insulting and shaming them for having undergone abortion.[106] The stigma and discrimination is particularly acute for adolescents, who are sometimes assumed by providers to be prostitutes, unmarried, and/or promiscuous.[107] Some medical providers may even be unaware

that providing PAC is legal,[108] particularly after the Ministry of Health withdrew the Standards and Guidelines which also provided guidance on the provision of PAC. Furthermore, the recording of PAC in patients' medical history can expose them to harassment by law enforcement officials or family members,[109]—a predicament medical staff use to extort bribes from patients.[110]

II. Violence against Adolescent Girls including Harmful Traditional Practices

In the LOIs the Committee asked the government to **"clarify whether all forms of violence… are prohibited in all settings, and indicate the measures taken in practice to combat violence, abuse and harassment committed in the home and in educational and care institutions."[111]** In response, the government stated that, per the Constitution, "every child has the right to be protected from abuse, neglect, harmful traditional practices [and] all forms of violence."[112] It also mentioned the development of the Prevention against Domestic Violence Act 2015 which "provides for punishment of all offenders who violate this right."[113] The government, however, failed to include other measures it is undertaking to implement these laws and ensure that adolescents are protected from all forms of violence and provide comprehensive services to survivors.

In addition, The Committee also inquired about **statistical data on the number of incidences of violence, including sexual violence, against children, information on the investigation and prosecution of the perpetrators, and the sentences given by courts.[114]** In response, the government admitted that "violence against children is a serious problem in Kenya with lifetime consequences for victims."[115] It further cited the study conducted by the government and UNICEF which revealed that "73 per cent of boys and 66 per cent of girls have experienced physical violence before the age of 18" and that "[v]iolence against children is mostly committed by persons closest to them, including parents, relatives, figures of authority such as teachers and religious leaders.[116] The government further states that based on this study, it has developed an action plan aimed at combating and preventing violence. It did not specify what these strategies are, whether they are being implemented effectively or their impact on reducing the level of violence against children. Despite the Committee's request, the response also did not include information on the number of cases that were reported, investigated and prosecuted.

Indeed, in Kenya, violence against adolescent girls continues to be pervasive. Recent survey results revealed that one in three Kenyan girls experience some form of sexual violence before the age of 18.[117] A household survey of more than 3,000 young people aged 13 to 24 showed that three out of four had experienced physical, sexual, or emotional violence.[118] Of those who had experienced violence, six out of ten had been physically abused.[119] Rape is rarely reported as a result of pervasive social stigma and a deep mistrust in police and the criminal justice system. A 2012 UNICEF study determined that only 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.[120] Sexual violence against girls and adolescents is also a significant problem in schools and other educational settings. According to a 2012 UNICEF study of women aged 18 to 24 who experienced unwanted sexual touching before the age of 18, about 25% reported that the first incident took place in school.[121] A report by the Kenya Teachers Service Commission (TSC) and the Centre for Rights Education and Awareness estimated that 12,660 girls were sexually abused by their teachers in Kenya between 2003 and 2007, although the report notes that 90% of sexual abuse cases go unreported.[122]

In *W.J. & Another v. Astarikoh Henry Amkoah & 9 Others*, a case in which the Center submitted an amicus brief, two adolescent girls were sexually abused by the Deputy Head teacher at Jamhuri Primary School in Nakuru County, Kenya.[123] The High Court of Kenya at Nairobi not only found the teacher civilly liable for sexual assault, but also determined that the government and Teachers Service Commission (TSC) handled the case inadequately. The Court ordered the government to provide financial reparations to the two girls and the TSC to update its guidelines to better handle sexual assault allegations.[124] Although the TSC circular, or employee guidelines, mentions disciplinary action for the sexual assault of students,[125] the circular fails to indicate clear mechanisms for disciplinary action or provide sexual assault survivors with psychological or essential health care.[126] The Government of Kenya must ensure that the TSC complies with the order of the High Court to end the practice of "shuffl[ing abusive teachers] from one school to another, and finally, content itself with dismissals."[127] The Government must also follow the Court's order to "put in place an effective mechanism"[128] to ensure that teachers are held accountable for any sexual abuse that they commit against their students.

Despite the legal protections that are in place, survivors of sexual and physical violence face a number of barriers that prevent them from receiving meaningful assistance from medical or legal professionals. These barriers include, but are not limited to: lack of comprehensive facilities where victims can report complaints, receive medical examination and treatment (including emergency contraceptives); lack of awareness among violence victims of the services that are available; difficulties in proving sexual violence; and the high cost of obtaining services after sexual violence.[129] Women and girls are also often reluctant to engage with the justice system as the police often harbor negative attitudes toward victims, and the victims are often subjected to societal stigma and are caused embarrassment in health facilities and police stations.[130]

Female Genital Mutilation (FGM)

In response to the inquiry from the Committee regarding **measures undertaken to combat harmful practices such as FGM,** the government cited the law against FGM which was passed in 2011 and the establishment of the Anti-FGM Board which mandated to formulate policies, mobilize resources, design and co-ordinate public awareness programs and advise the government on issues related to the FGM. It is also commendable that the government is implementing various initiatives such as the Cash Transfer Program to encourage parents to keep their girl children in school and not subject them to harmful practices, and the establishment of Children's Assembly at the county levels to ensure their participation with relevant authorities.[131] Nevertheless, it failed to specify the concrete steps it is taking to effectively enforce the law. It also did not provide additional information on the work of the Anti-FGM Board and the impact of the initiative in reducing FGM since its establishment. As the 2014 KDHS revealed 97.5% of women in Northeastern Kenya have undergone FGM[132] which has not shown any improvement from the rate recorded in the 2009 KDHS.[133] As the Committee against Torture, in its 2013 concluding observations, stated, Kenya "should redouble its efforts to eradicate the practice of female genital mutilation, including through awareness-raising campaigns and by prosecuting and punishing perpetrators of such acts. The State party should ensure that all measures to combat the practice comply with legal safeguards."[134]

III. Recommendations for the government of Kenya

Based on this information, we respectfully request that the Committee make the following recommendations to the government of Kenya:

1. Take the necessary steps to enable adolescents to have the information and resources necessary to make informed decisions about their sexual and reproductive health and rights, including guaranteeing all adolescents' access to comprehensive, scientifically accurate sexuality education, both in and out of schools, and establishing youth-friendly health centers, particularly in rural and low-income areas, where adolescents can access a full range of reproductive health services including contraceptives.

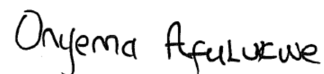
2. Expand its efforts to curb the high incidence of maternal mortality and ensure that adolescents have access to quality maternal health services. The government should take the necessary steps to effectively implement the Presidential Directive on Free Maternity Services including by allocating sufficient resources. It should undertake measures aimed at preventing the detention, abuse and mistreatment of adolescents in maternal health care facilities.

3. Ensure that adolescent girls can make autonomous and informed decisions about pregnancy, including by making sure that they have access to safe abortion services. To this end, the government should clarify the laws on abortion, reinstate the *"Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortions in Kenya"* and provide health care professionals with the necessary training and resources to provide quality, youth-friendly abortion and post-abortion care without bias or discrimination.

4. Institute investigation procedures and strict punishment for those, including teachers, found to have abused children. These procedures should include an oversight mechanism to help regulate and eradicate sexual and other violence against children, including those committed in schools. It should also establish a system to gather data on the number of cases reported, investigated and successfully prosecuted to monitor the effectiveness of the strategies it is implementing to address violence against children.

5. Intensify efforts to combat FGM including through allocating adequate resources to the Anti-FGM board and implementing the law against FGM.

Sincerely,



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[1] Committee on the Rights of the Child, *List of issues in relation to the combined third to fifth periodic reports of Kenya* LOIs, part I, para. 13, U.N. Doc. CRC/c/KEN/Q/3-5 (2015) [hereinafter CRC, *List of issues*].
[2] Committee on the Rights of the Child, *List of issues in relation to the combine third to fifth periodic reports of Kenya: Replies of Kenya to the list of issues*, para. 46, U.N. Doc. CRC/C/KEN/Q/3-5/Add.1 [hereinafter Replies of Kenya to the list of issues].
[3] *See* KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY: KEY INDICATORS 17, tbl. 3.9 (2015) [hereinafter KDHS 2014 SUMMARY].
[4] KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2008-2009 61 (2010) [hereinafter KDHS 2008-2009] (reporting that 46% of women used modern contraceptives).
[5] KDHS 2014 SUMMARY, *supra* note 3.
[6] *Id.*, at 21, tbl. 3.11.
[7]Joyce Mulama, *Health-Kenya: Contraceptives: Stock-Outs Threaten Family Planning*, (May 15, 2009), *available at* http://www.ipsnews.net/2009/05/health-kenya-contraceptives-stock-outs-threaten-family-planning/.
[8] CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 44-45 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf [hereinafter IN HARM'S WAY].
[9] MINISTRY OF MEDICAL SERVICES AND MINISTRY OF PUBLIC HEALTH AND SANITATION, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2010 101, *available at* http://dhsprogram.com/pubs/pdf/SPA17/SPA17.pdf.
[10] The study reported that most young girls get information—both accurate and myth—from their community: See Rhoune Ochako et al., *Barriers to Modern Contraceptive Methods Uptake Among Young Women in Kenya: A Qualitative Study*, 15 BMC PUB. HEALTH 118, 119 (2015), available at http://www.biomedcentral.com/content/pdf/s12889-015-1483-1.pdf [Ochako, *Barriers to Modern Contraceptive Methods*].
[11] IN HARM'S WAY, *supra* note 8, at 46.
[12] Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 10, at 119.
[13] IN HARM'S WAY, *supra* note 8, at 46.
[14] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 10, at 126.
[15] IN HARM'S WAY, *supra* note 8, at 47.
[16] *See* Ochako, *Barriers to Modern Contraceptive* Methods, *supra* note 10, at 126; IN HARM'S WAY, *supra* note 8, at 47–48.
[17] World Health Organization (WHO), *Fact Sheet No. 244*: *Emergency Contraception,* (2012), *available at* http://www.who.int/mediacentre/factsheets/fs244/en/ (last visited July 6, 2015).
[18] IN HARM'S WAY, *supra* note 8, at 47; International Consortium for Emergency Contraception, *EC Status and Availability: Kenya* (2015), *available at* http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/kenya/ (last visited, July 6, 2015) [hereinafter EC Status and Availability]
[19] IN HARM'S WAY, *supra* note 8, at 47.
[20] EC Status and Availability, *supra* note 19.
[21] IN HARM'S WAY, *supra* note 8, at 47–48.
[22] *Id.*, at 47.
[23] Dawn Chin-Quee et al., *Repeat Use of Emergency Contraceptive Pills in Urban Kenya and Nigeria* 40 INT'L PERSPECT. ON SEXUAL & REPRO. HEALTH 127, 127 (Sept. 2014) *available at* http://www.guttmacher.org/pubs/journals/4012714.pdf.
[24] IN HARM'S WAY, *supra* note 8, at 44.
[25] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, art. 14 (1) (b)-(c) CAB/LEG/66.6 (entered into force Nov. 25, 2005).
[26] KDHS 2008-2009, *supra* note 4, at 56.
[27] REPUBLIC OF KENYA, KENYA POPULATION SITUATION ANALYSIS, 42 (2013), *available at* http://countryoffice.unfpa.org/kenya/drive/FINALPSAREPORT.pdf [KENYA POPULATION SITUATION ANALYSIS].
[28] *See* WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2013 27, 29 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter WHO, TRENDS IN MATERNAL MORTALITY]; *see also* UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 28–29 (2013), *available at* *h*ttp://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2013/English2013.pdf.
[29] *See id.*, at 33. The KDHS 2008–2009 reported an even higher maternal mortality ratio (MMR) at 488 deaths per 100,000 live births: KDHS 2008–09, *supra* note 4, at 273.

[30] GUTTMACHER INSTITUTE, FACT SHEET: ABORTION AND UNINTENDED PREGNANCY IN KENYA (May 2012), *available at* www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf [hereinafter GUTTMACHER FACT SHEET 2012].
[31] WHO & UNITED NATIONS POPULATION FUND (UNFPA), PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5, 10 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.
[32] *Id.*, at 13-15.
[33] KDHS 2014 SUMMARY, *supra* note 3, at 24.
[34] *See id.* at 23, 24 tbl.3.13 (2015); *see also* WORLD HEALTH ORGANIZATION, *Antenatal Care (at least 4 visits)* (2015), http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited July 6, 2015).
[35] KDHS 2014 SUMMARY, *supra* note 3, at 23.
[36] *Id.*
[37] *See* WHO, RECOMMENDATIONS ON POSTNATAL CARE OF THE MOTHER AND NEWBORN 25 (2013), *available at* http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf.
[38] *See* KDHS 2014 SUMMARY, *supra* note 3, at 27.
[39] *Maternal Care Free, President Kenyatta Announces*, DAILY NATION, June 1, 2013, *available at* http://www.nation.co.ke/News/Govt-rolls-out-free-maternal-care/-/1056/1869284/-/gywvvrz/-/index.html.
[40] Beyond Zero: Inspiring Action. Changing Lives *available at* www.beyondzero.or.ke (last accessed December 14, 2015).
[41] *Id*.
[42] Beyond Zero Campaign Delivers the 22nd Mobile Clinic in Kakamega, April 9, 2015 *available at* http://www.ke.undp.org/content/kenya/en/home/presscenter/articles/2015/beyond-zero-campaign-delivers-the-22nd-mobile-clinic-in-kakamega.html.
[43] The examples cited herein come from the Center for Reproductive Rights and FIDA-Kenya's fact-finding report, CENTER FOR REPRODUCTIVE RIGHTS & FIDA KENYA, FAILURE TO DELIVER: VIOLATIONS OF WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 26 (2007) [hereinafter FAILURE TO DELIVER]. These findings were affirmed by a subsequent inquiry conducted by the Kenyan National Human Rights Commission. KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, REALIZING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR REALITY? A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA 47 (2012) [hereinafter KNCHR, PUBLIC INQUIRY].
[44] FAILURE TO DELIVER, *supra* note 43, at 7; KNCHR, PUBLIC INQUIRY, *supra* note 43, at 31.
[45] FAILURE TO DELIVER, *supra* note 43, at 28–29, 33–34.
[46] *Id*.
[47] *Id*.
[48] *Id*., at 29
[49] *Id*.
[50] *Id*.
[51] *Id*., at 31.
[52] *Id*., at 52.
[53] *Id*., at 53–54.
[54] *Id*., at 56.
[55] *Id*., at 63.
[56] *Id*., at 72–73.
[57] Awuor & Another v. A.G. of Kenya & 4 Others, Petition No. 562 of 2012, 7–9 (High Ct. Kenya, Nairobi).
[58] *Id.* at 21.
[59] *Id.* at 24.
[60] *Id.*
[61] *Id.* at 26.
[62] *Id.*, 45.
[63] *Maternal Care Free, President Kenyatta Announces*, DAILY NATION (June 1, 2013), http://www.nation.co.ke/News/Govt-rolls-out-free-maternal-care/-/1056/1869284/-/gywvvrz/-/index.html (last visited July 6, 2015).
[64] *See* KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, IMPLEMENTING FREE MATERNAL HEALTH CARE IN KENYA: CHALLENGES, STRATEGIES, AND RECOMMENDATIONS 6-7 (2013) [hereinafter KNCHR, FREE MATERNAL HEALTH CARE 2013], *available at* http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf.
[65] In the 2014/2015 budget, only about 4% of Kenya's budget is allocated to health, falling way short from its commitment under the Abuja declaration to allocate 15% of its budget to health: Press Release, Federation of

Women Lawyers Kenya, *On the Increasingly Troubling Trend of Maternal Deaths in Kenya* 1 (Jan. 20, 2014) *available at* http://fidakenya.org/wp-content/uploads/2014/02/PRESS-STATEMENT-ON-THE-INCREASING-TROUBLING-TREND-OF-MATERNAL-DEATHS-IN-KENYA-FINAL-1.pdf; *see* AFRICAN SUMMIT ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, 5, O.A.U. Doc. OAU/SPS/ABUJA/3 (Apr. 27, 2001), *available at* http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.

[66] A matron at PMH explained that the government was reimbursing them at a flat rate of Ksh 5,000 per delivery, even though the hospital used to charge Ksh 5,000 for normal deliveries and Ksh 10,000 for caesarian sections. This created a critical financial gap at the hospital: KNCHR, FREE MATERNAL HEALTH CARE 2013, *supra* note 64, at 6.

[67] Reuben Wanyama, *Kidero abolishes free maternity services in Nairobi County*, CITIZEN DIGITAL (Oct. 29, 2015), http://citizentv.co.ke/news/kidero-abolishes-free-maternity-services-in-nairobi-county-104439/.

[68] *Id.*

[69] Henry Owino, *Not So Free After All: Delivery Services the Only Free Package on Maternal Health Care*, REJECT 1, 4 (2013), *available at* http://issuu.com/awcfs/docs/reject_online_issue_87 [hereinafter Owino: *Not so Free*].

[70] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 6 (High Ct. Kenya, Bungoma).

[71] Owino: *Not so Free*, *supra* note 69, at 1, 4.

[72] *See* Reproductive Health Care Bill (2014), Senate Bills No. 17, KENYA GAZETTE SUPPLEMENT NO. 57 §§ 19-21, *available at* http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2014/ReproductiveHealthCareBill2014__1_.pdf [hereinafter Reproductive Health Care Bill (2014)].

[73] *See, e.g.*, Alinoor Moulid Bosh, *Dying to Give Birth in Northern Kenya*, AL JAZEERA (Jan. 15, 2015), http://www.aljazeera.com/indepth/features/2015/01/dying-give-birth-northern-kenya-201511411540230402.html Bosh(last visited July 6, 2015) [hereinafter Bosh, *Dying to Give Birth*]; Abdi Latif Dahir, *Kenya's Health Workers Claim Mismanagement*, AL JAZEERA (Jan. 13, 2014), http://www.aljazeera.com/indepth/features/2014/01/kenya-health-workers-claim-mismanagement-20141751735209910.html (last visited July 6, 2015).

[74] Majani v. A.G. of Kenya & 4 Others, Petition No. 5 of 2014, 4 (High Ct. Kenya, Bungoma).

[75] CRC, *List of issues*, *supra* note 1, Part I, para. 13.

[76] Replies of Kenya to the list of issues, *supra* note 2, para. 47.

[77] *Id.*

[78] The Penal Code, (2009) Cap. 63 §§ 158-60 (Kenya).

[79] MINISTRY OF PUBLIC HEALTH & SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 21 (2d ed., 2009), *available at* http://www.svri.org/nationalguidelines.pdf [hereinafter NATIONAL GUIDELINES ON SEXUAL VIOLENCE].

[80] MINISTRY OF HEALTH, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA Annex 11, 78 (3d ed., 2014) [hereinafter NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE, 2014].

[81] *See* Reproductive Health Care Bill (2014), *Supra note* 72, at §§ 20.

[82] IPAS, *Kenya approves new guidance for provision of safe abortion care,* October 22, 2012, *available at* http://www.ipas.org/en/News/2012/October/Kenya-approves-new-guidance-for-provision-of-safe-abortion-care.aspx (last visited Dec. 14, 2015).

[83] 50.50 inclusive democracy, *Why are women in Kenya still dying from unsafe abortions?*, Jan. 20, 2014, *available at* https://www.opendemocracy.net/5050/saoyo-tabitha-griffith/why-are-women-in-kenya-still-dying-from-unsafe-abortions (last visited Dec.14, 2015).

[84] Ministry of Health Office of the Director of Medical Services Memo, Re: Training on Safe Abortions and use of Medabon (Mifepristone+ Misoprostol) for Abortions, 24 February 2014 (on file with the Center for Reproductive Rights)

[85] *Id*.

[86] GUTTMACHER FACT SHEET 2012, *supra* note 30.

[87] *Id.*; *see also* Bernard Muthaka, *Penal code slowing down constitutional abortion care services,* STANDARD DIGITAL (2012)*, available at* http://www.standardmedia.co.ke/?articleID=2000072431&story_title=Kenya-Penal-code-slowing-down-constitutional-abortion-care-services.

[88] MINISTRY OF HEALTH, KENYA: INCIDENCE AND COMPLICATIONS OF UNSAFE ABORTION IN KENYA: KEY FINDINGS OF A NATIONAL STUDY 7 (August 2013) [hereinafter MINISTRY OF HEALTH, INCIDENCE AND COMPLICATIONS].

[89] *Id.*, at 25.

[90] KNCHR, PUBLIC INQUIRY, *supra* note 46.

[91] *See* Hudson Gumbihi, *Nairobi doctor reveals why more women are terminating pregnancies*, STANDARD DIGITAL (August 17, 2015), *available at* http://www.standardmedia.co.ke/health/article/2000173096/nairobi-doctor-reveals-why-more-women-are-terminating-pregnancies; Peace Loise & Brigid Chemweno, *Crude methods Kenyan girls are using to abort*, STANDARD DIGITAL, (August 16, 2015), *available at*

http://www.standardmedia.co.ke/health/article/2000173104/crude-methods-kenyan-girls-are-using-to-abort ((last visited August 30, 2015).; Mwangi; Muraguri & Linah Benyawa, *Girls in the Coast region using 'dangerous' drugs to end pregnancies*, STANDARD DIGITAL, (August 18, 2015), *available at* http://standardmedia.co.ke/article/2000173119/girls-using-dangerous-drugs-to-end-pregnancies (last visited Dec. 14, 2015).

[92] Vincent Mabatuk, *Rouge medical practitioners operate with amazing ease in Nakuru*, STANDARD DIGITAL, (August 17, 2015), *available at* http://standardmedia.co.ke/article/2000173121/rogue-medical-practitioners-operate-with-amazing-ease-in-nakuru?articleID=2000173121&story_title=rogue-medical-practitioners-operate-with-amazing-ease-in-nakuru&pageNo=1 (last visited August 30, 2015).

[93] FAILURE TO DELIVER, *supra* note 43, at 24-25. Half of the women treated by a hospital for complications from unsafe abortion were under the age of 20.

[94] GUTTMACHER INSTITUTE, IN BRIEF: ABORTION AND UNINTENDED PREGNANCY IN KENYA 3 (2012), *available at* http://www.guttmacher.org/pubs/IB_UnsafeAbortionKenya.pdf [hereinafter IN BRIEF: ABORTION AND UNINTENDED PREGNANCY].

[95] MINISTRY OF HEALTH, INCIDENCE AND COMPLICATIONS, *supra* note 88, at 21.

[96] IN BRIEF: ABORTION AND UNINTENDED PREGNANCY, *supra* note 94. "Women and men interviewed in 2002–2003 were aware that the strict abortion law led women to procure unsafe procedures from 'quacks,' and they believed that rich women could obtain relatively safe abortions, while poorer women were more likely to die from unsafe procedures."); IN HARM'S WAY, *supra* note 8, at 59-60.

[97] IN HARM'S WAY, *supra* note 8, at 59-60.

[98] *Id*.

[99] UNITED NATIONS CHILDREN'S FUND (UNICEF), STATISTICS: KENYA, *available at* http://www.unicef.org/infobycountry/kenya_statistics.html.

[100] *See* KNCHR, PUBLIC INQUIRY, *supra* note 43, at 49–59; IN HARM'S WAY, *supra* note 8, at 76.

[101] NATIONAL POST ABORTION CARE CURRICULUM FOR SERVICE PROVIDERS: TRAINEES HANDBOOK 1-24, *available at* http://www.postabortioncare.org/sites/pac/files/MOHKen_National_Curriculum_Service_Providers.pdf.

[102] The training manual provides that "[c]omprehensive PAC is a life-saving procedure that should be available to all women and provision of comprehensive post-abortion care does not lead to punishment or withdrawal of registration of the service provider." It does not, however, address the issue of women who are deterred from seeking PAC for fear of prosecution. *Id.* at 1-24.

[103] *See* Abdhalah Kassira Ziraba et al., *Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors*, 15 BMC PREGNANCY AND CHILDBIRTH 7 (2015).

[104] *See id.*

[105] IN BRIEF: ABORTION AND UNINTENDED PREGNANCY, *supra* note 94, at 2. IN HARM'S WAY, *supra* note 8, at 88–90.

[106] FAILURE TO DELIVER, *supra* note 43, at 25; IN HARM'S WAY, *supra* note 8, at 92–93.

[107] IN HARM'S WAY, *supra* note 8, at 92–93.

[108] IN HARM'S WAY, *supra* note 8, at 76–78 (noting further that fears of prosecution are not unfounded despite the legality of the treatment).

[109] FAILURE TO DELIVER, *supra* note 43, at 25.

[110] IN HARM'S WAY, *supra* note 8, at 90–92.

[111] CRC, *List of issues, supra* note 1, Part I, para. 7.

[112] Replies of Kenya to the list of issues, *supra* note 2, para. 25.

[113] *Id*., para. 26.

[114] CRC, *List of issues, supra* note 1, Part III, para. 2.

[115] Replies of Kenya to the list of issues, *supra* note 2, para. 99.

[116] *Id*.

[117] *See* Katy Migiro, *One Third of Kenyan Girls Subjected to Sexual Violence - Survey*, REUTERS (Nov. 28, 2012), http://www.trust.org/trustlaw/news/one-third-of-kenyan-girls-subjected-to-sexual-violence-survey (last visited July 6, 2015) [hereinafter Migiro, *One third of Kenyan girls*]; UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA: FINDINGS FROM A 2010 NATIONAL SURVEY 2 (2010) [hereinafter UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA].

[118] This information was not disaggregated into male and female statistics. *See* Migiro, *One third of Kenyan girls*, *supra* note 117; *see also* UNICEF, HIDDEN IN PLAIN SIGHT: A STATISTICAL ANALYSIS OF VIOLENCE AGAINST CHILDREN 85 (2014).

[119] *Id*.

[120] Professional help includes assistance provided by institutions such as the police department, medical facilities, legal aid, religious groups and/or social services. Female victims, especially adolescents, are far more likely to seek assistance from their families or close friends. UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA, *supra* note 117, at 129, tbl.7.2.1.
[121] *See id.* at 52, fig. 6.1.2; *see also* Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION (Nov. 1, 2009), *available at* http://allafrica.com/stories/200911020402.html (last visited July 6, 2015).
[122] Samuel Siringi, *Shocking Details of Sex Abuse in Schools*, DAILY NATION, NOV. 1, 2009, cited in IN HARM'S WAY, *supra* note 8, at 42.
[123] W.J. & Another v. Astarikoh Henry Amkoah & 9 Others, Judgment, Petition 311 of 2011 (2015) eKLR paras. 10, 14-15, 19-22 (High Ct. Kenya, Nairobi), *available at* http://kenyalaw.org/caselaw/cases/view/109721/.
[124] *Id.* paras. 111–12, 123.
[125] *Id.* paras. 123, 132–33, 150.
[126] *See* Brief for the Center for Reproductive Rights as Amicus Curiae Supporting Petitioners at 3, W.J. & Another v. Astarikoh Henry Amkoah & 9 Others, Petition 311 of 2011 (2015) eKLR (High Ct. Kenya, Nairobi), *available at* http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/PETITION-331-OF-2011-CENTER-FOR-REPRODUCTIVE-RIGHTS-AMICUS-BRIEF.pdf.
[127] W.J. & Another, (2015) eKLR, para. 179.
[128] *Id.*
[129] KNCHR, PUBLIC INQUIRY, *supra* note 43, at 82-83.
[130] *Id*., at 83; S*ee* Migiro, *One third of Kenyan girls*, *supra* note 117.
[131] Replies of Kenya to the list of issues, *supra* note 2, para. 35.
[132] *See* KDHS 2014 SUMMARY, *supra* note 3, at 61, tbl.3.42.
[133] *See* KDHS 2008-2009, *supra* note 4, at 265, tbl. 16.16.
[134] *See* CAT Committee, *Concluding Observations: Kenya*, para. 26, U.N. Doc. CAT/C/KEN/CO/2 (2013).

February 27, 2015

The Committee on the Rights of the Child

Re: Supplementary Information on Kenya scheduled for review by the Committee on the Rights of the Child during the 71st Pre-Sessional Working Group

Dear Committee Members,

The Center for Reproductive Rights (the Center) submits this pre-session letter to supplement the Republic of Kenya's report to the Committee on the Rights of the Child (the Committee).[1] The Center—a non-profit legal advocacy organization headquartered in New York City, with regional offices in Nairobi, Bogotá, Kathmandu, Geneva, and Washington, D.C.—uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect, and fulfill.

Reproductive rights lie at the heart of human rights for adolescent girls because upholding these rights is essential to ensuring their substantive equality and reproductive autonomy. Violations affect not only the health of these girls, but can have a significant impact on their education, development, and future prospects, perpetuating cycles of poverty and resulting in life-long exclusion and discrimination. Kenya is a party to multiple international human rights treaties that require state parties to ensure the sexual and reproductive rights of girls, including the Convention on the Rights of the Child (the Convention).[2] Despite this, adolescent girls in Kenya face numerous violations of their reproductive rights.

This letter highlights issues that affect the reproductive rights of girls in Kenya—in particular, the high incidence of maternal mortality and morbidity; lack of access to safe abortion and post-abortion care; lack of comprehensive family planning information and services; and high incidences of harmful and discriminatory practices including physical and sexual violence.

I. The Right to Equality and Non-Discrimination

The Convention strongly protects children's rights to substantive equality and nondiscrimination. For girls, right to equality and sexual and reproductive rights interact in a mutually reinforcing nature: the stigma surrounding sexuality, and the discrimination and inequalities that they face, can prevent them from accessing sexual and reproductive health services, and their inability to access such services can perpetuate cycles of inequality and discrimination.

The Committee has explicitly recognized that gender-based discrimination and taboos or negative attitudes about girls being sexually active often limits girls' access to preventive measures and other health services.[3] States "must give careful consideration to prescribed gender norms within their societies with a view to

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eliminating gender-based discrimination."[4] The gender-based discrimination that girls face in accessing health services or in schools may be particularly exacerbated in the context of sexual and reproductive health services, as a result of stigma and discrimination surrounding girls' sexuality. This dually jeopardizes girls' health and rights, as their reproductive capacities mean that they must shoulder the burden of an unplanned pregnancy and the social consequences. The Committee recognizes that, in the context of adolescent pregnancy, stigma, and discrimination can hinder girls' access to education and services.[5] Indeed, in many contexts, girls seeking to prevent pregnancy must also endure such stigma and discrimination.

States are obligated to ensure that children's rights are not undermined as a result of discrimination.[6] The Committee recognizes that children who are discriminated against "are more vulnerable to abuse, other types of violence and exploitation," and their health and development are put at greater risk.[7] As such, states must pay particular attention and afford protections to such children.[8] The Committee has called on states to take positive measures to alleviate such inequalities and discrimination, including by adopting policies and programs on children's health that are "grounded in a broad approach to gender equality that ensures young women's full political participation; social and economic empowerment; recognition of equal rights related to sexual and reproductive health; and equal access to information, education, justice and security, including the elimination of all forms of sexual and gender-based violence."[9] The Committee has urged states to pay particular attention to the different "needs of girls and boys, and the impact of gender-related social norms and values on the health and development of boys and girls."[10]

II. The Right to Sexual and Reproductive Health Services and Information (Articles 3 (2), 6, 17 and 24)

When adolescent girls are not able to access the full range of sexual and reproductive health information and services, their abilities to make meaningful choices about their reproductive lives, without coercion, is limited and can impact their enjoyment of their rights to life, health, equality, and non-discrimination, all of which receive broad protection under the Convention. For example, Article 6 recognizes that "every child has the inherent right to life."[11] Article 24 similarly recognizes the right "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health[,]" and requires states to take appropriate measures "to develop ... family planning education and services," "to ensure appropriate pre-natal and post-natal health care for mothers," and to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."[12] Moreover, Article 3 (2) requires each state to "take all appropriate legislative and administrative measures" to ensure that children have the protection and care necessary for their well-being.[13] Finally, Article 17 requires states to ensure that children have access to a diverse range of information, including health-related information.[14]

a. Maternal health of adolescents

The Committee has noted that "preventable maternal mortality and morbidity constitute grave violations of the human rights of women and girls and pose serious threats to their own and their children's right to health."[15] Under the convention, states have an obligation to diminish maternal mortality and morbidity, through measures such as providing a continuum of care for reproductive and maternal health, and conducting regular maternal mortality audits.[16] In its 2007 Concluding Observations on Kenya, the Committee expressed concern over the high rate of teen pregnancy and the lack of access to reproductive health services contributing to maternal mortality among adolescent girls, and recommended that the state assess the problems and formulate policies focused on teen pregnancies.[17] Similarly, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) has expressed concern over "the very high number of teenage pregnancies" in Kenya and the fact that "the existing sex education programmes are not sufficient, and may not give enough attention to the prevention of early pregnancy and control of sexually transmitted infections (STIs)."[18] The CEDAW Committee has further recommended that Kenya

"promote education on sexual and reproductive health and rights targeted at adolescent girls and boys with special attention to the prevention of early pregnancy."[19]

However, early pregnancy remains high in Kenya. In fact, 103 of every 1000 pregnancies are attributed to girls between 15 and 19 years of age.[20] Fifteen percent of girls aged 15-19 have either given birth or are pregnant by the age 19.[21] This is highly problematic since early pregnancy in Kenya has been singled out as a major contributor to the overall maternal mortality, which remains alarmingly high.[22] The latest Demographic Health Survey (2008-09) (Kenya DHS) estimates put the maternal mortality ratio (MMR) at 488 maternal deaths per 100,000 live births.[23] According to the World Health Organization (WHO), the MMR for Kenya has decreased by an average of only 0.8% per year since 1990.[24] In some low-income areas, the estimated MMR is as high as 706 deaths per 100,000 births.[25] These figures are far higher than the MMR of 175 or less that Kenya has committed to achieve by 2015—this year—as part of the United Nations' Millennium Development Goals.[26]

Apart from a disproportionate risk of death during and after child birth,[27] adolescent girls also face increased vulnerability to pregnancy-related complications.[28] However, they often lack access to ante-natal, delivery and post-natal care; maternal health care services that are essential to preventing maternal mortality and morbidity. As the Kenya DHS shows, less than half of pregnant women and adolescents attend the WHO recommended[29] four or more ante-natal care visits.[30] The proportion of births managed by health care professionals and the proportion delivered in a health facility stand only at 44% and 43%, respectively.[31] Further, about 53% of Kenyan women and adolescents do not receive the post-natal care they need;[32] and only 28% receive post-natal care within four hours of delivery while only 7% receive such care between four and 23 hours.[33]

The Kenyan Government has repeatedly acknowledged that maternal mortality in Kenya remains unacceptably high,[34] and attributes this high rate to the lack of physical and economic access to health information, care and services;[35] the Kenya DHS revealed that 45% of girls below the age of 20 mentioned distance and lack of transportation as a reason for not delivering at a health care facility.[36] These factors are exacerbated by the lack of skilled service providers and high rates of poverty.[37] The Ministry of Health and the National Coordinating Agency for Population and Development have identified maternal health as a priority issue and set a goal of reducing maternal mortality by 77% by the year 2030.[38] However, currently, very few health care facilities in the country are fully equipped and prepared to provide the comprehensive, quality maternal health care that would be required to meet this goal.[39]

In recent years, the Kenyan government has made some efforts to address the issue. For example, in June 2013, the Kenyan Government issued a Presidential Directive which provided that all pregnant women and adolescents would be able to, "access free maternity services in all public health facilities."[40] In January 2014, the First Lady of Kenya spearheaded the Beyond Zero Campaign to raise awareness about the link between good health and a strong nation, specifically demonstrating the importance of maternal, newborn, and children's health.[41] The Campaign has delivered eighteen mobile clinics since its inception.[42] In its current report to the Committee, however, the government has failed to provide details regarding the adequacy of the Campaign and any other initiatives given the continued high levels of maternal mortality.

Detention, abuse and neglect of adolescent girls seeking maternal health services in health care facilities

Women and adolescent girls often encounter detention, neglect and abuse from health care professionals and staff while seeking maternal health care services.[43] The Center, along with Federation of Women Lawyers-Kenya, published a fact-finding report on the quality of maternal health care in Kenya that revealed the prevalence of delays and a lack of adequate medical care at maternal health care facilities.[44] For instance, many who sought maternity care at Pumwani Maternity Hospital (PMH) recounted being told to find their own way to the delivery ward and to lift themselves onto the maternity bed while they were in labor.[45] They also reported not being provided with adequate information about the health services or procedures available to them, or being denied such services altogether.[46]

The research also documented systematic abuses in the administration of reproductive health services, including physical and verbal abuse, such as rough treatment during labor.[47] Interviewees recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[48] The research further found delays in medical care during labor or while waiting for stitches after delivery, and instances of some being stitched without anesthesia causing them to endure excruciating pain.[49]

The situation is particularly worse for adolescents as they, due to their age, most often encounter discrimination and abuse from the health care professionals.[50] One interviewee, who attended PMH as an adolescent, reported the treatment she received: "the nurses came and started abusing me, saying, 'You young girl, what were you looking for in a man? Now you can't even give birth.'"[51] Another who gave birth while in secondary school recalled the neglect she experienced during delivery saying[52]:

> "I remember I was a kid and when I was asked to push I didn't know what to push. I pushed till I went for a long call [had a bowel movement]. The nurses left me and told me it's my problem."

In addition to the abusive treatment pregnant adolescents face while seeking maternal health care, the Center's research also revealed that they are frequently denied maternity health care if they fail to pay the initial deposit for such services, both in private and in public health care facilities.[53] Even after admission to facilities, they may be denied essential and often life-saving treatment if they fail to pay their remaining balance.[54] In many cases, those who are unable to pay the required fees for services rendered during their labor and delivery are detained at the health care facilities, often without post-natal care and basic necessities, such as bedding and food for themselves and their newborns.[55] This requirement for a payment of a fee disproportionately affects adolescents who are more likely not to have any independent means of income.

Despite the aforementioned free maternity care directive, serious problems remain regarding access to maternal health care services. Hospital infrastructure and staffing cannot support the additional number of patients who come seeking free maternal health care due to the directive,[56] and the Kenyan Government has failed to allocate additional resources to remedy this issue.[57] Furthermore, there have been no clear guidelines set by the government about how to implement the free maternal services. Although some facilities have reportedly been given extra money to cover the influx of deliveries, others have remained uncertain of how to balance the new policy of free care with their need to cover costs.[58] Further, although the Kenyan Government has dictated that maternal health services would be free for all, in reality, not all costs associated with giving birth have been eliminated.[59] Basic goods required for delivery, such as cotton wool and the medications used to induce labor, still have to be purchased.[60] Public health specialists have also recently noted that structural problems, such as far-flung maternity units, low staff motivation, poor road networks, and inadequate ambulance services, still exist making it hard to implement the directive.[61] Other main components of maternal health services, including ante-natal and post-natal care, are also not covered under the directive.[62]

Also the declaration of free services has not solved the problem of abuse and neglect in health care facilities; the situation may have even become worse due to the issues addressed above. For instance, a recent news report focused on a woman who was forced to give birth while standing at Nyeri Hospital because there was no nurse to attend to her, and the baby fell on the floor and died from the impact.[63] The continued abuse has also been demonstrated by a recent case filed by the Center at the Bungoma High Court where the petitioner was forced to give birth on the floor, while unconscious,—without any assistance from the health care professionals.[64] She subsequently awoke to two nurses shouting at her and slapping her for dirtying the hospital floor by delivering her baby on it.[65]

b. Lack of access to safe abortion and post-abortion care

Unsafe abortion is one of the most easily preventable causes of maternal mortality. Even if death does not occur, adolescents may suffer long-term complications such as chronic pelvic pain or intestinal obstruction.[66] The Convention mandates that governments "ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal."[67] In Kenya, unsafe abortions contribute to the particularly high mortality rate amongst adolescent girls. Indeed, Committee has expressed concern that "the high rates of teenage pregnancies [and] the criminalization of the termination of pregnancies in cases of rape and incest" have contributed to elevated incidences of maternal mortality among adolescent girls in Kenya.[68] Consequently, the Committee has recommended that Kenya formulate policies and programs focused on the prevention of teenage pregnancies and unsafe abortions.[69]

The laws governing abortion in Kenya are confusing and conflicting. While the Constitution of Kenya was amended in 2010 to allow for abortion in emergency situations and where the health of a woman is at risk—in addition to situations where the life of the mother is in danger[70]—the penal code has not been revised to reflect this change.[71] This means that a woman can still be held criminally liable for terminating a pregnancy that poses a risk to her health even though abortion in such circumstance is allowed under the Constitution. Moreover, Kenya's 2004 *National Guideline on the Medical Management of Rape/Sexual Violence* provides that "[t]ermination of pregnancy is allowed in Kenya after rape" since it is allowed under the 2006 Sexual Offences Act,[72] which contradicts both the Constitution and the Penal Code. None of these laws and policies allow abortions when the pregnancy is as a result of incest or when there is fetal impairment. The U.N. Human Rights Committee,[73] the Committee,[74] the CEDAW Committee,[75] and the Committee against Torture (the CAT Committee)[76] have all recognized the different facets of Kenya's restrictions on access to safe, legal abortion as violating international human rights norms.[77]

Due to this lack of clarity in the law, some health care providers refuse to provide abortion services, because they mistakenly believe the procedure to be illegal.[78] The confusion was further compounded by recent actions of the Ministry of Health and Director of Medical Services. Following the 2010 Constitutional amendment, the Ministry of Health developed and approved the *"Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortions in Kenya"* ("Standards and Guidelines"), which clarified the circumstances in which medical professionals could perform safe abortion services.[79] However, this Standards and Guidelines were subsequently withdrawn under unclear circumstances, leaving health care workers without official guidance as to when abortions were legal.[80] Further, in 2013, the Director of Medical Services issued a memo to all health care workers saying that "[t]he Constitution of Kenya 2010 is clear that abortion on demand is illegal...." without clarifying the circumstances under which it is legal.[81] The memo further stated that it is illegal for health care workers to participate in trainings on either safe abortion care or the use of abortion drugs, and threatened health care workers who choose to take these training with legal and professional sanctions.[82] These threats against health care workers significantly limit access to safe abortion not only by incentivizing health care workers to avoid prosecution by turning away those seeking safe and legal abortion, but also by stymying health care workers' access to the medical information and professional skills needed to safely perform the procedure.

These confusion and restrictions in Kenyan laws, compounded with the lack of safe abortion services in the country, increase adolescents' susceptibility to resort to unsafe abortions. Indeed, in its 2012 public inquiry, the Kenyan National Commission on Human Rights (KNCHR) found that many resort to "crude methods" administered by unqualified persons to terminate pregnancies, due to lack of abortion services in Kenya.[83] The KNCHR further found that adolescents suffered from particularly high rates of maternal and perinatal mortality, given that "[t]hey lack easy access to quality and friendly [sexual reproductive health] ... services [and] safe abortion services."[84] Indeed, the report notes that unsafe abortions were "said to be rampant among adolescents and youth."[85] The KNCHR further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya.[86]

The government's failure to ensure access to safe and legal abortion, including for victims of sexual violence, and to address the existing legal uncertainties have sustained the high levels of unsafe abortion-related injuries and death in the country. A study based on data from a nationally-representative sample of public and private sector hospitals and health facilities found that nearly 465,000 induced abortions occurred in Kenya in 2012—a rate of 48 per 1,000 women of reproductive age.[87] This rate is significantly higher than most countries in Africa and the world as a whole.[88] Moreover, "[t]he data on the high proportion of moderate and severe post-abortion complications, coupled with limited comprehensive abortion care training throughout Kenya, indicate that the majority of the induced abortions that occur are unsafe."[89] Kenyan adolescents commonly obtain abortions using unsafe methods and unqualified providers,[90] and "as many as 60% of all gynecologic emergency hospital admissions are due to abortion complications."[91] According to a 2015 publication, in 2012, an estimated 119,912 women experienced complications from induced abortions, approximately 40% of which were classified as moderate and 37% as severe.[92] An estimated 266 per 100,000 of women die from unsafe abortions, a rate almost nine times higher than in the developed world,[93] and unsafe abortions are estimated to cause 35-50% of all maternal deaths.[94]

The harshness of Kenya's abortion laws is particularly harmful to those who are young[95] and those with low income among whom the unintended pregnancy rate is highest.[96] As data from the Ministry of Health shows, 45% of adolescent girls aged 19 and younger and 47% of female students who sought post-abortion care experienced severe complications.[97] Even where relatively safe abortion procedures are available, the cost of these services generally exceeds the economic resources of those who need them.[98] Although the cost of safe abortions varies widely depending on the clinic and stage of pregnancy, it may range from approximately USD 13 to USD 132.[99] Conversely, herbalists and unqualified individuals may charge as little as USD 4.[100] With the average daily income of Kenyans amounting to only USD 2.30, the price disparity between safe and unsafe abortion is a drastic one, particularly for adolescents and students who are likely not to have an income.[101]

In addition, many—adolescents in particular—do not know about Kenya's abortion laws or believe that abortion is prohibited entirely.[102] This results in a reluctance to even attempt to discuss abortion with, or seek abortion services from, a qualified health care provider.[103] Adolescents' lack of knowledge of abortion laws is doubly dangerous in that they also result in a reluctance to seek post-abortive care when it is necessary.[104] Although post-abortion care "is legal and not punishable by any part of Kenya laws," the Ministry of Health itself acknowledges that "[l]ack of knowledge of the law ... leads to the fear of criminal prosecution by [the post-abortion care] provider, and mistreatment of women needing care because they are regarded as criminals."[105] Moreover, despite its legality, those who seek post-abortion care are still sometimes arrested.[106]

Even the qualified providers that do offer abortion services sometimes subject patients to degrading or abusive treatment.[107] The stigma and discrimination is particularly acute for adolescents, who are sometimes assumed by providers to be prostitutes or promiscuous.[108] Many patients are reluctant to seek post-abortive care for the same reasons. Studies indicate that a large number of medical personnel, particularly nurses, are inadequately trained, leading to lengthy wait times for an adequately trained doctor or other medical professional.[109] In addition, health care workers are sometimes verbally abusive to those seeking post-abortion care, and sometimes delay or refuse to provide the needed care.[110] Health care workers also sometimes extort bribes from patients fearful of having their medical history recorded and exposed to law enforcement officials and family members.[111]

In its current State Report to the Committee, Kenya did not discuss the issue of unsafe abortions or what it is doing to address its dire impact on girls' lives.[112]

c. Lack of comprehensive family planning information and services

The Committee maintains that "States should ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents, including family planning and safe abortion services."[113] States should also ensure that "[a]ttention … be given to ensuring confidential, universal access to [family planning] good and services for both married and unmarried female and male adolescents."[114] Specifically, the Committee maintains that "[s]hort term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided."[115] In 2011, the CEDAW Committee called upon Kenya to "expand efforts to increase knowledge of and access to affordable contraceptive methods throughout the country and ensure that women in rural areas do not face barriers in accessing family planning information and services; and widely promote education on sexual and reproductive health and rights targeted at adolescent boys and girls."[116]

However, according to the Kenya DHS, Kenya's contraceptive prevalence rate (CPR) is only 45.5%,[117] just a 6.2% increase from the numbers reported in 2003.[118] Moreover, the rate remains very low for adolescents as the CPR for those aged 15 to 24 is only 14.1%. Twenty-five percent of women and adolescents aged 15 to 49 have an unmet need for contraception.[119] This low rate of contraceptive usage is largely due to the barriers that women and particularly adolescent girl face in accessing family planning services. Many public health facilities face a profound shortage of contraceptives.[120] In many cases, their preferred method of contraception may be unavailable.[121] For many, financial barriers further prevent access to contraceptives. Despite the Ministry of Health's policy that contraceptives should be available free of charge, many government health facilities charge their patients "user fees" for family planning services and some charge for the contraceptive method itself.[122] Community and familial attitudes and opinions towards contraception also prevent some from accessing contraceptives that would otherwise be available to them.[123] This is particularly problematic for adolescents, as most face social stigma and discrimination if they attempt to access family planning services.[124]

In its recent report to the Committee, Kenya states that "[t]he State Party, through the Ministry of Education has designated teachers who offer counselling in schools to prevent unwanted pregnancies. Reproductive health (Sex Education) is taught in primary and secondary schools as party of Social Studies and Ethics."[125] However, young people in Kenya continue to be misinformed about contraceptive use and their reproductive health,[126] directly leading to a higher incidence of unplanned and unwanted pregnancies.[127] Despite Kenya's sex education policies and programs, sexual education both at home and in schools is inadequate.[128] Few adolescents actually receive sexual education and those that do are often taught by inadequately trained teachers.[129] Moreover, opposition from parents, religious organizations and some civil society groups results in sexual education that either omits or severely limits teaching contraceptive use and safe sex.[130]

Emergency contraception

Many adolescent girls could avoid unplanned and unwanted pregnancies by using emergency contraception (EC), a safe and effective means of preventing pregnancy following unprotected sex and a critical component of care for survivors of sexual violence.[131] Indeed, Kenya's Ministry of Public Health and Sanitation has recognized that EC "is an important component of adolescent reproductive health."[132] EC is available in Kenya and the Ministry of Health broadly recommends its use "or those "who have had unprotected sexual intercourse and desire to prevent pregnancy."[133] It is also included in Kenya's essential drugs list and the *National Family Planning Guidelines for Service Providers*, which provides for the provision of the method without any age or other restrictions.[134]

However, very few adolescent girls in Kenya know about EC. From all who were surveyed in the DHS, only 0.5% of adolescent girls aged 15-19 have ever used EC despite the high incidence of sexual violence against this age group, discussed below.[135] The level of usage has not shown much improvement in recent

years as a 2014 study found out that only 17% of women and adolescent girls surveyed in Nairobi have ever used EC.[136] This lack of usage can be attributed to the numerous barriers they encounter in accessing the method. As with other forms of contraceptives, EC are not always readily available.[137] Private health care facilities may not always offer EC and Catholic Church-owned facilities and those under the Christian Health Association of Kenya do not provide emergency contraception even though they provide services to victims of sexual violence.[138] Moreover, Kenyan public health facilities are often insufficiently stocked.[139] Even though the Ministry of Health's EC guidelines state that it "should be used after unprotected sex" and "can be safely used by adolescents" and such guidelines do not further limit the conditions for dispensement,[140] EC is commonly denied those who need it for reasons that are arbitrary, misinformed, or both, including but not limited to instances where it was withheld "because the person look[ed] young."[141]

III. Harmful and Discriminatory Practices Against Adolescent Girls

Harmful practices including physical and sexual violence are demonstrations of the inequality and discrimination adolescent girls encounter in their day to day lives. Where girls' rights to equality and non-discrimination are not fulfilled, the inequalities and discrimination they face have a grave impact on their present and future lives. As such, Article 2 of the Convention prohibits discrimination on a number of grounds (including sex and other status), and mandates states to take all appropriate measures to protect children.[142] Additionally, Article 34 obliges states to take all appropriate measures to protect the child against all forms of exploitation and sexual abuse.[143] Despite these explicit protections in the Convention, young girls and adolescents in Kenya continue to experience these harmful and discriminatory practices at a young age.

a. Sexual and physical violence against girls

Gender-based violence has been addressed in many of the concluding observations issued by various treaty monitoring bodies with respect to Kenya in the past decade.[144] Specifically, the Committees have noted the high prevalence of sexual and physical violence within Kenya.[145] Furthermore, they have noted the continued incidence of rape, including marital rape, and the social legitimization of such violence as evidenced by the underreporting of these incidents.[146]

While Kenya's current report to the Committee discusses various legal frameworks and regimes that have been enacted to outlaw harmful practices against women and girls, the state fails to outline how these laws are administered and enforced. For example, the State Report discusses the Prohibition of Female Genital Mutilation Act, 2011, but does not address the enforcement or effectiveness of this statute.[147] The State Report is also silent on the specific issue of sexual violence within schools, and fails to mention any steps taken or contemplated to remedy the prevalence of such issue. Further, despite the passage of the Sexual Offences Act of 2006 as an improvement over earlier laws on sexual violence, marital rape and domestic violence are still not punishable offenses at law. This is significant since more than one in three women and adolescent girls subjected to sexual violence report that the perpetrator was either a current or former husband or boyfriend.[148]

Although there is widespread underreporting of sexual-related crimes, statistics show that violence and abuse against women and girls are a pervasive problem in Kenya. Recent survey results show that one in three Kenyan girls experience some form of sexual violence before the age of 18.[149] Further, based on a household survey of more than 3000 young people aged 13 to 24, three out of four have experienced physical, sexual, or emotional violence.[150] Six out of ten have been physically abused.[151] Rape is rarely reported due to social stigma and a widespread lack of faith in police and the criminal justice system; only 3% of sexually abused girls received professional help in the form of medical, psychological, or legal assistance.[152] Another study shows that 50% of girls between the ages of 15 and 19 that ever experienced physical and/or sexual violence ever told anyone about it.[153]

Despite the legal protections that are in place, survivors of sexual and physical violence face a number of barriers that prevent them from receiving meaningful assistance from medical or legal professionals. These barriers include, but are not limited to: lack of comprehensive facilities where victims can report complaints, receive medical examination and treatment (including emergency contraceptives); lack of awareness among sexual violence victims of the services that are available; difficulties in proving sexual violence; and the high cost of obtaining services after sexual violence.[154] Many, particularly girls, are also often reluctant to engage in the justice system as the police often harbor negative attitudes toward victims, and they are often subjected to societal stigma and are caused embarrassment in health facilities and police stations.[155]

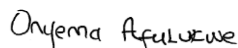
We ask that the Committee consider addressing the following questions to the Government of Kenya:

1. What measures is the government taking to reduce the high maternal mortality and morbidity and ensure adolescent girls receive adequate ante-natal, delivery and post-natal care? What steps are being taken to ensure the implementation of the free maternity care directive is comprehensive and sustainable particularly by allocating the necessary resources and ensuring that health care facilities are adequately equipped and staffed?
2. What concrete measures is the government going to take to improve the training of health care providers about patients' rights and eliminate the abuse and neglect by medical and hospital staff of those seeking maternal care services? How does the government propose to ensure that those who experience abuse are able to report and seek redress?
3. What measures is the government undertaking to clarify its laws on abortion and ensure access to legal, safe abortion and post-abortion services? What measures is the government taking to implement the 2013 recommendation of the Committee against Torture that Kenya "amend its legislation, in order to grant those who have been subjected to rape or incest the right to abortion, independent of any medical professional's discretion"?[156] What steps is the government undertaking to reinstate the Standards and Guidelines on Safe abortion and withdraw the memo that prohibits health care professionals from attending trainings on safe abortions.
4. What measures does the government plan to undertake to remove the barriers adolescent girls face in accessing contraceptive services, including by ensuring that they have access to comprehensive sexual and reproductive health information and services?
5. What measures has the government taken to prioritize and adequately address the high incidence of sexual violence? What specific actions has the government taken to ensure that perpetrators are prosecuted and held responsible? What measures has the government taken to ensure that victims of sexual violence are aware of, and have access to legal and health services?

We hope that this information is useful during the Committee's review of Kenya. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

Evelyne Opondo
Regional Director
Africa Program
Center for Reproductive Rights



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[1] THE REPUBLIC OF KENYA 3RD, 4TH AND 5TH STATE PARTY REPORT TO THE UNCRC COMMITTEE-GENEVA 2005-2011, *available at* http://tbinternet.ohchr.org/Treaties/CRC/Shared%20Documents/KEN/CRC_C_KEN_3-5_6676_E.pdf (last visited Jan. 7, 2015) [hereinafter KENYA STATE PARTY REPORT].
[2] Convention on the Rights of the Child, art. 24, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*adopted* Nov. 20, 1989, *entered into force* Sept. 2, 1990). *See also,* International Covenant on Civil and Political Rights, arts. 3, 6, 23, 26 ,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 (*adopted* Dec. 10, 1948, *entered into force* Mar. 23, 1976, *acceded* May 1, 1972); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), arts. 10, 12,14(2)(b), 16(1)(e), G.A. Res 34/189, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc.A/34/46, U.N.T.S. 13 (*adopted* Dec. 18, 1979, *entered into force* Sept. 3, 1981); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), art. 16, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51 U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*adopted* Dec. 10, 1984, *entered into force* June 26, 1987, *acceded* Feb. 21, 1997); International Covenant on Economic Social and Cultural Rights (ICESCR), arts. 3, 6, 23, 26, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6313 (1966) (*adopted* Dec. 16, 1966, *entered into force* Jan. 3, 1976); African Charter on Human and Peoples' Rights, arts. 3, 16, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*adopted* June 27, 1981, *entered into force* Oct. 21, 1986, *ratified* Jan. 23, 1992); African Charter on the Rights and Welfare of the Child (Children's Charter), arts. 14, 16, 21, 27, O.A.U. Doc. CAB/LEG/24.9/49 (*adopted* Jul. 11, 1990, *entered into force* Nov. 29, 1999, *ratified* Jul. 25, 2000); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, Doc CAB/LEG/66.6 (2000) (*adopted* July 11, 2003, *entered into force* Nov. 25, 2005, *ratified* Oct. 13, 2010); Under Chapter 1, Section 2(5) of the 2010 Kenyan Constitution, any treaty ratified by Kenya forms part of the law of Kenya. CONSTITUTION OF KENYA (2010), Chap. 1, §2(6) ("Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution.")
[3] Committee on the Rights of the Child (CRC Committee), *General Comment 3:HIV/AIDS and the rights of the child*, (32nd Sess.), para. 8, U.N. Doc. CRC/GC/2003/3 (2003).
[4] *Id*.
[5] CRC Committee, *Concluding Observations: Guyana,* para. 50, U.N. Doc. CRC/C/GUY/CO/2-4 (2013).
[6] CRC Committee, *General Comment 15: The right of the child to the enjoyment of the highest attainable standard of health*, (62nd Sess.), para. 8-9, U.N. Doc. CRC/C/GC/15 (2013) [hereinafter CRC Committee, *General Comment 15*].
[7] CRC Committee, *General Comment 4: Adolescent health and development*, (33rd Sess.), para. 6, U.N. Doc. CRC/GC/2003/4 (2003).
[8] *Id*.
[9] CRC Committee, *General Comment 15*, *supra* note 6, para. 10.
[10] *Id.* para. 9.
[11] Convention on the Rights of the Child, art. 6, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*adopted* Nov. 20, 1989, *entered into force* Sept. 2, 1990).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] CRC Committee, *General Comment 15*, *supra* note 6, para. 51.
[16] *Id*., para. 34.
[17] CRC Committee, *Concluding observations: Kenya*, (44th Sess.), para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).
[18] CEDAW Committee, *Concluding Observations: Kenya*, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).
[19] *Id.* para. 38(e).
[20] REPUBLIC OF KENYA, KENYA POPULATION SITUATION ANALYSIS 42 (2013) [hereinafter KENYA POPULATION SITUATION ANALYSIS].
[21] KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2008-2009 52 (2010) [hereinafter KDHS 2008-2009].
[22] KENYA POPULATION SITUATION ANALYSIS, *supra* note 20, at 42.
[23] KDHS 2008-2009, *supra* note 21, at xxi.
[24] WORLD HEALTH ORGANIZATION (WHO), TRENDS IN MATERNAL MORTALITY: 1990 TO 2013 39 (2014).
[25] KDHS 2008-2009, *supra* note 21at 273.
[26] Guttmacher Institute, *Abortion and Unintended Pregnancy in Kenya* (2012), *available at* www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf [hereinafter *Abortion and Unintended Pregnancy in Kenya*].

[27] WHO & UNITED NATIONS POPULATION FUND (UNFPA), PREGNANT ADOLESCENTS: DELIVERING ON GLOBAL PROMISES OF HOPE 5, 10 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241593784_eng.pdf.
[28] *Id*. at 13-15.
[29] WHO, *Antenatal Care (at least 4 visits)* (2015), *available at* http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited Feb. 24, 2015).
[30] KDHS 2008-2009, *supra* note 21, at 116: 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.
[31] KDHS 2008-2009, *supra* note 21, at xxi.
[32] *Id.* at 124.
[33] *Id.* at 124.
[34] MINISTRY OF HEALTH OF THE REPUBLIC OF KENYA, NATIONAL REPRODUCTIVE HEALTH POLICY: ENHANCING REPRODUCTIVE HEALTH STATUS FOR ALL KENYANS 10 (2007), *available at* http://hivaidsclearinghouse.unesco.org/search/resources/kenya_National_Reproductive_Health_Policy_booklet_2007.pdf.
[35] *Id.*
[36] KDHS 2008-2009, *supra* note 21, at 121 table 9.7.
[37] Government of Kenya, *Consideration of Reports Submitted by States Parties under Article 18 of CEDAW: Seventh Periodic Reports of States Parties: Kenya,* para. 203, U.N. Doc. CEDAW/C/Ken/7 (2009); MINISTRY OF HEALTH OF THE REPUBLIC OF KENYA, NATIONAL REPRODUCTIVE HEALTH POLICY: ENHANCING REPRODUCTIVE HEALTH STATUS FOR ALL KENYANS 11 (2007), *available at* http://hivaidsclearinghouse.unesco.org/search/resources/kenya_National_Reproductive_Health_Policy_booklet_2007.pdf.
[38] MINISTRY OF MEDICAL SERVICES & MINISTRY OF PUBLIC HEALTH AND SANITATION, KENYA HEALTH POLICY 2012-2030 32 (2013), *available at* http://countryoffice.unfpa.org/kenya/drive/FinalKenyaHealthPolicyBook.pdf.
[39] UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID), GLOBAL HEALTH INITIATIVE: KENYA STRATEGY 2011-2014 4 (2011), *available at* http://www.ghi.gov/documents/organization/158455.pdf; NATIONAL CO-ORDINATING AGENCY FOR POPULATION AND DEVELOPMENT, THE MINISTRY OF HEALTH, AND THE CENTRAL BUREAU OF STATISTICS, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2004 128-40 (2005). 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.
[40] *Maternal Care Free, President Kenyatta Announces*, DAILY NATION, Jun. 1, 2013, *available at* http://www.nation.co.ke/News/Govt-rolls-out-free-maternal-care/-/1056/1869284/-/gywvvrz/-/index.html.
[41] *See Beyond Zero,* www.beyondzero.or.ke (last visited Feb. 6, 2015).
[42] *Id.*
[43] CENTER FOR REPRODUCTIVE RIGHTS & FEDERATION OF WOMEN LAWYERS (FIDA)-KENYA, FAILURE TO DELIVER: VIOLATIONS ON WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 26 (2007) [hereinafter FAILURE TO DELIVER]. These findings were affirmed by a subsequent inquiry conducted by the Kenyan National Human Rights Commission. KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, REALIZING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A MYTH OR REALITY? A REPORT OF THE PUBLIC INQUIRY INTO VIOLATIONS OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA 47 (2012) [hereinafter A MYTH OR REALITY?].
[44] FAILURE TO DELIVER, *supra* note 43, at 7; A MYTH OR REALITY?, *supra* note 43, at 31.
[45] A MYTH OR REALITY?, *supra* note 43, at 31.
[46] FAILURE TO DELIVER, *supra* note 43, at 36–37.
[47] *Id.* at 28–29, 33–34.
[48] *Id*.
[49] *Id.*
[50] *Id*. at 29.
[51] *Id*. at 29.
[52] *Id*. at 31.
[53] *Id.* at 52.
[54] *Id.* at 53-54.

[55] *Id.* at 56.
[56] *See* KENYA NATIONAL COMMISSION ON HUMAN RIGHTS (KNCHR), IMPLEMENTING FREE MATERNAL HEALTH CARE IN KENYA: CHALLENGES, STRATEGIES AND RECOMMENDATIONS 6-7 (2013), *available at* http://www.knchr.org/Portals/0/EcosocReports/Implementing%20Free%20Maternal%20Health%20Care%20in%20Kenya.pdf [hereinafter KNCHR REPORT].
[57] Currently, only about 6% of Kenya's budget is allocated to health, falling short from its commitment under the Abuja declaration to allocate 15% of its budget to health. FIDA Kenya, *On the Increasingly Troubling Trend of Maternal Deaths in Kenya* 1 (Jan. 20, 2014), *available at* http://fidakenya.org/wp-content/uploads/2014/02/PRESS-STATEMENT-ON-THE-INCREASING-TROUBLING-TREND-OF-MATERNAL-DEATHS-IN-KENYA-FINAL-1.pdf.
[58] A matron at PMH explained that the government was reimbursing them at a flat rate of Ksh 5,000 per delivery, even though the hospital used to charge Ksh 5,000 for normal deliveries and Ksh 10,000 for caesarian sections. This created a critical financial gap at the hospital. KNCHR REPORT, *supra* note 56, at 6.
[59] Henry Owino, *Not So Free After All: Delivery Services the Only Free Package on Maternal Health Care*, REJECT 1, 4 (2013), *available at* http://issuu.com/awcfs/docs/reject_online_issue_87.
[60] Bungoma Petition, In the High Court of Kenya at Bungoma 6 (2014) (on file with the Center for Reproductive Rights) [hereinafter Bungoma Petition].
[61] Chesang, Kipruto, *Better plan needed in Kenya's health sector*, STANDARD DIGITAL NEWS, Jan. 5, 2015, http://www.standardmedia.co.ke/worldcup/article/2000146789/better-plan-needed-in-kenya-s-health-sector?articleID=2000146789&story_title=better-plan-needed-in-kenya-s-health-sector&pageNo=1 (last visited Feb. 6, 2015).
[62] Henry Owino, *Not So Free After All: Delivery Services the Only Free Package on Maternal Health Care*, REJECT 1, 4 (2013), *available at* http://issuu.com/awcfs/docs/reject_online_issue_87.
[63] *Pregnant Woman Forced to Give Birth While Standing in Nyeri Hospital*, STANDARD MEDIA, Jan. 17, 2014, http://www.standardmedia.co.ke/ktn/video/watch/2000074070/-pregnant-woman-forced-to-give-birth-while-standing-in-nyeri-hospital (last visited Feb. 24, 2015).
[64] Bungoma Petition, *supra* note 60, at 4.
[65] *Id.*
[66] CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 9 (2010) [hereinafter IN HARM'S WAY].
[67] CRC Committee, *General Comment 15*, *supra* note 6, para. 70.
[68] CRC Committee, *Concluding observations: Kenya*, (44th Sess.), para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007).
[69] *Id.*
[70] CONSTITUTION, art. 26(1)(4) (Kenya).
[71] The Penal Code (2009) Cap. 63 Secs. 158–60 (Kenya).
[72] MINISTRY OF HEALTH AND SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 21 (2009).
[73] U.N. Human Rights Committee, *Consideration of Reports submitted by States parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Committee: Kenya*, para. 14, U.N. Doc. CCPR/CO/83/KEN29 (2005) ("The Committee expresses concern about the high maternal mortality rate prevalent in the country, caused, inter alia, by a high number of unsafe or illegal abortions (article 6 of the Covenant).").
[74] CRC Committee, *Concluding observations: Kenya*, (44th Sess.), para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007) ("The Committee … is concerned at … the criminalization of the termination of pregnancies in cases of rape and incest….").
[75] CEDAW Committee, *Concluding Observations: Kenya*, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011) ("While welcoming the introduction of free antenatal services for pregnant women, the Committee expresses its concern that the maternal mortality rate, including deaths resulting from unsafe abortions, and the infant mortality rate remain high.").
[76] Committee against Torture, *Concluding Observations: Kenya*, para. 28, CAT/C/KEN/CO/2 (2013).
[77] In 2005, the Human Rights Committee recommended that Kenya "review its abortion laws, with a view to bringing them into conformity" with the International Covenant on Civil and Political Rights (ICCPR). The CEDAW Committee has also recommended that Kenya adopt "measures to increase ... access to safe abortion." The CAT recommended in 2013 that Kenya "amend its legislation, in order to grant women who have been subjected to rape or incest the right to abortion, independently of any medical professional's discretion." CRC Committee, *Concluding observations: Kenya*, (44th Sess.), para. 49, U.N. Doc. CRC/C/KEN/CO/2 (2007); CEDAW Committee,

Concluding Observations: Kenya, para. 37-38, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Committee against Torture*, Concluding Observations: Kenya*, para. 28, CAT/C/KEN/CO/2 (2013).
[78] IN HARM'S WAY, *supra* note 66, at 60-63.
[79] *Kenya approves new guidance for provision of safe abortion care,* IPAS, Oct. 22, 2012, http://www.ipas.org/en/News/2012/October/Kenya-approves-new-guidance-for-provision-of-safe-abortion-care.aspx (last visited Feb. 24, 2015).
[80] *Why are women in Kenya still dying from unsafe abortions?* 50.50 INCLUSIVE DEMOCRACY, Jan. 20, 2014, https://www.opendemocracy.net/5050/saoyo-tabitha-griffith/why-are-women-in-kenya-still-dying-from-unsafe-abortions (last visited Feb. 24, 2015).
[81] Ministry of Health Office of the Director of Medical Services Memo, Re: Training on Safe Abortions and use of Medabon (Mifepristone+ Misoprostol) for Abortions, 24 February 2014 (on file with the Center for Reproductive Rights)
[82] *Id.*
[83] A MYTH OR REALITY?, *supra* note 43 at 47.
[84] *Id.* at xxiii.
[85] *Id.* at 110.
[86] *Id.* at 66–67.
[87] MINISTRY OF HEALTH, KENYA, INCIDENCE AND COMPLICATIONS OF UNSAFE ABORTION IN KENYA: KEY FINDINGS OF A NATIONAL STUDY 17 (2013), *available at* http://www.guttmacher.org/pubs/abortion-in-Kenya.pdf [hereinafter INCIDENCE AND COMPLICATION OF UNSAFE ABORTION IN KENYA].
[88] *Id.* The World Health Organization estimates the case-fatality rate in developed regions to be 30 per 100,000.
[89] *Id.*
[90] *Abortion and Unintended Pregnancy in Kenya, supra* note 26.
[91] *Id.*; *see also* Bernard Muthaka*, Penal code slowing down constitutional abortion care services,* STANDARD DIGITAL, Dec. 9, 2012, http://www.standardmedia.co.ke/?articleID=2000072431&story_title=Kenya-Penal-code-slowing-down-constitutional-abortion-care-services (last visited Feb. 24, 2015).
[92] INCIDENCE AND COMPLICATION OF UNSAFE ABORTION IN KENYA, *supra* note 87, at 7; Abdhalah Kassira Ziraba et al., *Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors*, 15 BMC PREGNANCY AND CHILDBIRTH 3 (2015).
[93] *Id.* at 25.
[94] A MYTH OR REALITY?, *supra* note 43, at 46.
[95] FAILURE TO DELIVER, *supra* note 43, at 24-25. Half of the women treated by a hospital for complications from unsafe abortion were under the age of 20.
[96] *Abortion and Unintended Pregnancy in Kenya, supra* note 26, at 3.
[97] INCIDENCE AND COMPLICATION OF UNSAFE ABORTION IN KENYA*, supra* note 87, at 21.
[98] *Abortion and Unintended Pregnancy in Kenya, supra* note 26, at 2 ("Women and men interviewed in 2002–2003 were aware that the strict abortion law led women to procure unsafe procedures from 'quacks,' and they believed that rich women could obtain relatively safe abortions, while poorer women were more likely to die from unsafe procedures."); IN HARM'S WAY, *supra* note 66, at 59-60.
[99] IN HARM'S WAY, *supra* note 66, at 59-60
[100] *Id.*
[101] UNITED NATIONS CHILDREN'S FUND (UNICEF) STATISTICS: KENYA, *available at* http://www.unicef.org/infobycountry/kenya_statistics.html.
[102] IN HARM'S WAY, *supra* note 66, at 58-59.
[103] *Id*.
[104] FAILURE TO DELIVER, *supra* note 43, at 25.
[105] NATIONAL POST ABORTION CARE CURRICULUM FOR SERVICE PROVIDERS: TRAINEES HANDBOOK 1-24, *available at* http://www.postabortioncare.org/sites/pac/files/MOHKen_National_Curriculum_Service_Providers.pdf.
[106] IN HARM'S WAY, *supra* note 66, at 77-78.
[107] *Id.* at 63.
[108] *Id.* at 46.
[109] *Abortion and Unintended Pregnancy in Kenya, supra* note 26, at 2; A MYTH OR REALITY?, *supra* note 43, at 47–48; IN HARM'S WAY, *supra* note 66, at 88-90.
[110] FAILURE TO DELIVER, *supra* note 43, at 25; IN HARM'S WAY, *supra* note 66, at 92-95.
[111] IN HARM'S WAY, *supra* note 66, at 90-92.
[112] *See* KENYA STATE PARTY REPORT, *supra* note 1.

[113] CRC Committee, *General Comment 15*, *supra* note 6, para. 2(d).
[114] *Id.,* para. 2(f)(c).
[115] *Id.*
[116] CEDAW Committee, *Concluding Observations: Kenya*, para. 38(d), U.N. Doc. CEDAW/C/KEN/CO/7 (2011)
[117] KDHS 2008-2009, *supra* note 21, at 61.
[118] MINISTRY OF HEALTH, NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2012-2016 8 (2013), *available at* http://www.fhi360.org/sites/default/files/media/documents/kenya-costed-implementation.pdf.
[119] Maura Graff, *Family Planning Is a Crucial Investment for Kenya's Health and Development*, Populations Reference Bureau, *available at* http://www.prb.org/Publications/Articles/2012/kenya-family-planning.aspx; KDHS 2008-2009, *supra* note 21, at 61.
[120] Joyce Mulama, *Health-Kenya: Contraceptives: Stock-Outs Threaten Family Planning*, INTER PRESS SERVICE (May 15, 2009), http://www.ipsnews.net/2009/05/health-kenya-contraceptives-stock-outs-threaten-family-planning/ (last visited Feb. 24, 2015).
[121] IN HARM'S WAY, *supra* note 66, at 44-45.
[122] MINISTRY OF HEALTH AND SANITATION, KENYA SERVICE PROVISION ASSESSMENT SURVEY 2010 101 (2010), *available at* http://dhsprogram.com/pubs/pdf/SPA17/SPA17.pdf .
[123] For example, women report their husbands becoming angry and intervening when they began using contraceptives: *Family Planning in Kenya: Not for Women Only,* UNFPA, Jul. 1, 2009, http://www.unfpa.org/public/News/pid/3015 (last visited Feb. 24, 2015).
[124] One young woman recounts being turned away when she attempted to get an intra-uterine coil: "... they said no at the government facility. They said you are a Muslim girl, you are going to burn in hell. She was a Muslim nurse and refused to give me contraceptives." IN HARM'S WAY, *supra* note 66, at 46.
[125] KENYA STATE PARTY REPORT, *supra* note 1, para. 242.
[126] IN HARM'S WAY, *supra* note 66, at 47.
[127] *Id.* at 47-48.
[128] *Abortion and Unintended Pregnancy in Kenya, supra* note 26, at 2; Kafuli Agbemenu et al., *An Integrative Review of Comprehensive Sex Education for Adolescent Girls in Kenya*, JOURNAL OF NURSING SCHOLARSHIP, 43, 54-63 (2011) [hereinafter *Review of Sex Education in Kenya*].
[129] *Abortion and Unintended Pregnancy in Kenya, supra* note 26, at 2; *Review of Sex Education in Kenya*, *supra* note 128.
[130] Sammy Cheboi, *Sex Education Lacking, Says Health Official*, THE DAILY NATION, Sept. 23, 2009, http://allafrica.com/stories/200909230822.html (last visited Feb. 24, 2015).
[131] WHO, *Emergency Contraception Fact Sheet* (2012), *available at http://www.who.int/mediacentre/factsheets/fs244/en/*.
[132] MINISTRY OF HEALTH AND SANITATION, DIVISION OF REPRODUCTIVE HEALTH (KENYA), EMERGENCY CONTRACEPTION: HEALTH CARE PROVIDERS QUICK REFERENCE GUIDE 1 (2008), *available at* http://www.popcouncil.org/uploads/pdfs/RH_ECQuickRefGuide.pdf [hereinafter QUICK REFERENCE GUIDE].
[133] *Id.* at 2.
[134] International Consortium for Emergency Contraception, *Counting What Counts: Tracking Access to Emergency Contraception* 1 (2013), *available at* http://www.cecinfo.org/custom-content/uploads/2013/05/ICEC-Kenya-Fact-Sheet-2013.pdf.
[135] KDHS 2008-2009, *supra* note 21, at 60, tbl. 5.3.
[136] DAWN CHIN-QUEE ET AL., REPEAT USE OF EMERGENCY CONTRACEPTIVE PILLS IN URBAN KENYA AND NIGERIA 129 (2014) *available at* http://www.guttmacher.org/pubs/journals/4012714.pdf.
[137] IN HARM'S WAY, *supra* note 66, at 47-48.
[138] *Id.* at 44.
[139] *Id.* at 47 n.258.
[140] QUICK REFERENCE GUIDE, *supra* note 132, at 3.
[141] IN HARM'S WAY, *supra* note 66, at 47.
[142] Convention on the Rights of the Child, art. 19, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*adopted* Nov. 20, 1989, *entered into force* Sept. 2, 1990).
[143] *Id.*
[144] *See, e.g.*, Human Rights Committee, *Concluding Observations: Kenya*, para. 15, U.N. Doc. CCPR/C/KEN/CO/3 (2012); CEDAW Committee, Concluding Observations: Kenya, paras 17-24, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); Human Rights Council, *Universal Periodic Review: Kenya*, para. 101.48-53, U.N. Doc. A/HRC/15/8 (2010).
[145] CEDAW Committee, *Concluding Observations: Kenya*, paras 17-24, U.N. Doc. CEDAW/C/KEN/CO/7 (2011).

[146] *See, e.g., id.*, para. 21.
[147] KENYA STATE PARTY REPORT, *supra* note 1, paras 252-260.
[148] UNICEF, HIDDEN IN PLAIN SIGHT: A STATISTICAL ANALYSIS OF VIOLENCE AGAINST CHILDREN 77 (2014) [hereinafter HIDDEN IN PLAIN SIGHT].
[149] *See* Katy Migiro, *One third of Kenyan girls subjected to sexual violence - survey*, REUTERS, Nov. 28, 2012, http://www.trust.org/trustlaw/news/one-third-of-kenyan-girls-subjected-to-sexual-violence-survey (last visited Feb. 24, 2015) [hereinafter Migiro, *One third of Kenyan girls*]. *See also*, UNICEF, VIOLENCE AGAINST CHILDREN IN KENYA: FINDINGS FROM A 2010 NATIONAL SURVEY 2 (2010).
[150] This information was not disaggregated into male and female statistics. *See* Migiro, *One third of Kenyan girls*, *supra* note 149; *see also* HIDDEN IN PLAIN SIGHT, *supra* note 148, at 85.
[151] HIDDEN IN PLAIN SIGHT, *supra* note 148, at 85.
[152] *See id.* at 85, 90-91. Professional help includes assistance provided by institutions such as the police department, medical facilities, legal aid, religious groups and/or social services. Female victims, especially adolescents, are far more likely to seek assistance from their families or close friends.
[153] *Id.* at 88.
[154] KNCHR REPORT, *supra* note 56, at 82-83.
[155] *Id.* at 83.
[156] Committee against Torture, *Concluding Observations: Kenya*, para. 28, CAT/C/KEN/CO/2 (2013).