CENTER FOR REPRODUCTIVE RIGHTS

Submission to the United Nations Universal Periodic Review of

KENYA

21st Session of the UPR Working Group of the Human Rights Council

January – February 2015

Report on Kenya's Compliance with its Human Rights Obligations in the Area of Women's Reproductive and Sexual Health

Submitted by:

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June 15, 2014

In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the "Center") submits this letter to supplement the report of the government of Kenya, scheduled for review by the Human Rights Council during its 21st session (Jan-Feb. 2015). The Center is a non-profit legal advocacy organization headquartered in New York with regional offices in Nairobi, Katmandu, Bogota and Geneva that uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to respect, protect and fulfill.

Kenya is a party to multiple international human rights treaties that require state parties to ensure the sexual and reproductive rights of women and girls.[1] Under Article 2(5) (6) of the 2010 Kenyan constitution (the Constitution), any treaty ratified by Kenya forms part of the law of Kenya.[2] Despite this, Kenyan women and girls face numerous violations of their reproductive rights, including lack access to reproductive health information and services. This letter highlights the following issues the Center hopes the Human Rights Council will take into account during its review of Kenya: (i) lack of access to maternal health services, including the abuse and illegal detention of women in health care facilities; (ii) lack of access to safe abortion and post-abortion care services; (iii) lack of access to family planning information and services; and (iv) sexual and physical violence against women and girls.

1. RIGHTS TO REPRODUCTIVE HEALTH INFORMATION AND SERVICES

(a) Access to Maternal Health Care

Maternal death is defined by the World Health Organization (WHO) as any death that occurs during pregnancy, childbirth, or within 42 days after birth or termination of a pregnancy.[3] Such deaths in Kenya are most often the result of a lack of access or availability of quality maternal health care services.[4] International human rights law recognizes that states have a duty to ensure women's right to safe motherhood and emergency obstetric services.[5] The Committee on the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW Committee) has recognized high maternal mortality as a violation of women's rights to health and life and stated that—"[m]any women are at risk of death or disability from pregnancy-related causes because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services."[6] In addition, the CEDAW Committee has recognized that the denial of or the failure to provide adequate women's health care services including maternal care is a form of discrimination against women.[7] Further, the CESCR defines the right to health as an inclusive right, which encompasses, "the right to a system of health protection which provides equality of opportunity for people to enjoy the best attainable level of health,"[8] and requires state parties to ensure that health services are available, accessible, acceptable and of good quality.[9]

In Kenya, according to a 2012 report from the UN, every year, approximately 360 women die per every 100,000 live birth.[10] Data from the latest Kenya Demographic Health Survey (KDHS) report even a higher maternal mortality ratio at 488 deaths per 100,000 live births. [11] In some low-income areas, the estimated maternal mortality is as high as 706 deaths per 100,000 births.[12] These figures are far higher than the mortality rate of 175 or less that Kenya has committed to achieve by 2015 as part of the Millennium Development Goals (MDGs).[13] Concerned about these high maternal mortality ratios, several treaty monitoring bodies, including the CEDAW Committee, the Committee on Economic, Social and Cultural Rights (CESCR Committee) and the Committee on the Convention on the Rights of the Child (CRC Committee)[14] have urged Kenya to strengthen its efforts to reduce maternal mortality by increasing awareness and access to maternal health care facilities, in particular by increasing the number of clinics and trained personnel in rural areas.[15]

According to the most recent available data, less than half of pregnant women in Kenya attend the WHO recommended[16] four or more ante-natal care visits.[17] The proportion of births managed by health care professionals and the proportion delivered in a health facility stand only at 44% and 43%, respectively.[18] Further, about 53% of Kenyan women do not receive the post-natal care they need;[19] only 28% of women receive post-natal care within four hours of delivery while only 7% receive such care between four and 23 hours.[20]

The Kenyan government has repeatedly acknowledged that maternal mortality in Kenya remains unacceptably high,[21] and attributes this high rate to the lack of physical and economic access to health information, care and services. [22] These factors are exacerbated by the lack of skilled service providers and high rates of poverty.[23] The Ministry of Health and the National Coordinating Agency for Population and Development have also identified maternal health as a priority issue and set a goal of reducing maternal mortality by 77% by the year 2030.[24] However, currently, very few healthcare facilities in the country are fully equipped and prepared to provide the comprehensive, quality maternal healthcare that would be required to meet this goal.[25]

(i) The abuse and neglect of women seeking maternal health services in health care facilities

In addition to the lack of access the maternal health care services, women who attend such services often encounter neglect and abuse from health care professionals and staffs.[26] As the fact-finding research conducted by the Center and FIDA-Kenya on the issue—which subsequently led to a public inquiry by Kenyan National Human Rights Commission (KNHRC)— revealed, women experience delays and a lack of adequate medical care at the maternal health care facilities.[27] For instance, women arriving 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 are in labor.[28] These women also report not being provided with adequate information about the health services or procedures available to them or, even, denial of such services.[29]

In addition, the report documented systematic abuses with the provision of reproductive health services, including physical and verbal abuse for women seeking the services, and rough treatment during labor.[30] Women recounted rough, painful, and degrading treatment during physical examinations and delivery, as well as verbal abuse from nurses if they expressed pain or fear.[31] The research also found delays in medical care during labor or while waiting for stitches after delivery, including being stitched without anesthesia, causing women to endure excruciating pain.[32]

One woman, who gave birth at St. Mary's hospital in Langata, was subject to verbal and physical abuse by a medical provider during delivery.[33] During the delivery, the medical provider treated her so roughly that she feared for her and her baby's life. However, she was already in labor, and in this extremely vulnerable state, she was unable to stop the abusive treatment. The provider further subjected her to terrible pain and suffering by mutilating her genitals with a sharp object without her consent.[34] As of the submission of this letter, she has not obtained redress for the abuse and ill-treatment she suffered in the hands of the health care provider even though she reported the incident to the police, hospital authorities, as well as Kenya Medical Practitioners and Dentist Board. FIDA- Kenya filed a case in a Kenyan High Court on behalf of the woman and the Center was admitted as amicus curiae, but the case has been unduly prolonged and is still pending.

Another woman, who attended PMH, also recounted how no hospital staff assisted her during labor and one nurse told her to "stop pretending to be in pain."[35] When her pain worsened, she was told by a staff member to continue suffering because she was responsible for her own pregnancy.[36] At night, when her pain intensified, she had to crawl to the nurses for assistance, who, instead of helping her, mocked her, asking if she was exercising.[37] When her water broke she had to walk to the delivery ward on her own and was assisted by another patient who had just delivered her baby.[38]

In response to these abuses, the Center, in 2012 filed a case at High Court of Kenya at Nairobi highlighting the abuse women face while attending maternal health care, and seeking declaration that such treatments are violations of their rights.[39] One of the petitioners in this case, for instance, was mistreated and treated inhumanly at 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 after 2 hours of arrival.[40] Due to the delay in emergency care, her bladder ruptured after her caesarean section.[41] Her suffering was compounded by the fact that her wound was also infected and the stitching had been poorly

performed.[42] To make matters worse, during the days following her caesarean section, she was detained because she was unable to pay her hospital fees, and forced to sleep on a cold floor without any subsequent medical care.[43]

(ii) The illegal detention of women in health care facilities for failure to pay maternity health care fees

In addition to the inhuman and abusive treatment women face in maternal health care, the fact-finding report also revealed that women in Kenya are often detained for failure to pay the fees for the delivery services.[44] 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.[45] One woman recounted witnessing a women near labor being harassed at a hospital entrance and then turned away because she could not pay the admission fee.[46] Even after admission women may be denied essential and often life-saving treatment if they fail to pay their remaining balance.[47] In many cases, women 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.[48] Both petitioners in the aforementioned case filed by the Center were made to sleep on the floor—one was even forced to sleep next to a toilet, which consistently flooded.[49] There is also a lack of effective internal and external mechanisms through which women can get redress for these violations of their human rights.[50] Even when redress mechanisms are available, women often do not know about them or lack the necessary information on how to access them.[51]

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."[52] However, despite this initiative, serious problems remain. Hospital infrastructure and staffing cannot support the additional number of women who come seeking free maternal health care due to this declaration,[53] and the government has failed to allocate additional resources to remedy this issue. [54] 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.[55] Further, although the government has said that maternal health services would be free for women, in reality, not all costs associated with giving birth have been eliminated.[56] Women still have to purchase basic goods required for delivery, such as cotton wool and the medications used to induce labor, straining their resources.[57] Other main components of maternal health services, including ante-natal and post-natal care, are also not covered under the directive.[58]

In addition, even with the declaration of free services, women continue to face abuse and mistreatment in health care facilities: in fact, the situation may become worse as health care professionals and staff have to attend to additional women. For instance, recently it was reported on the news that a woman 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.[59] The continued abuse has also be 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 –and became unconscious as a result—without any assistance from the health care professionals: she subsequently awoke to two nurses shouting at her and slapping her for dirtying the hospital floor by delivering her baby right there.[60]

(b) Lack of access to safe abortion and post-abortion care services

In Kenya, unsafe abortion accounts for one-third of maternal deaths[61] and this can be attributed to the numerous barriers women face in accessing safe abortion services. The laws governing abortion in Kenya are confusing and conflicting. While the Constitution of Kenya was amended in 2010 to allow for abortion in situations where health of a woman is at risk—in addition to situations where the life of the mother is in danger[62]—the penal code has not been revised to reflect this change.[63] 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, the 2004 *National Guideline on the Medical Management of Rape/Sexual Violence* provides that "[t]ermination of

pregnancy is allowed in Kenya after rape" since it is allowed under the 2006 Sexual Offences Act,[64] contradicting the Constitution and the Penal Code. Moreover, 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,[65] the CRC Committee,[66] the CEDAW Committee,[67] and the Committee Against Torture (CAT Committee)[68] have all recognized the different facets of Kenya's restrictions on access to safe, legal abortion as violating international human rights norms.[69] To this day, however, Kenya has failed to comply with the recommendations of these Committees and clarify the laws on abortion and expand the grounds for the procedure to include exceptions for rape, incest and fetal impairment.

Such confusions and restrictions compounded with lack of safe abortion services force women to resort to clandestine abortions, which are often unsafe, subjecting women to grave pain and suffering. Indeed, in its 2012 public inquiry, the KNCHR found that women resort to "crude methods," administered by unqualified persons to terminate pregnancies, due to lack of abortion services in Kenya.[70] The KNHRC further concluded that restrictive abortion laws contribute significantly to high maternal mortality and morbidity in Kenya.[71] The government's failure to ensure access to safe and legal abortion, including for victims of sexual violence, and to address the existing uncertainties have sustained the high levels of unsafe abortion-related injuries and death in the country. A 2002 study of women treated for post-abortion complications estimates that more than 300,000 abortions occur in Kenya each year.[72] It further found that Kenyan women commonly obtain abortions using unsafe methods and unqualified providers,[73] and "that as many as 60% of all gynecologic emergency hospital admissions are due to" complications from unsafe abortion.[74] It concluded that the numbers of maternal death due to unsafe abortion is high.[75] At least 2,600 women die from complications relating to unsafe abortions annually.[76] The harshness of Kenya's abortion laws also impacts young[77] and low income women, among whom the unintended pregnancy rate is highest,[78] more heavily because, even where relatively safe abortion procedures are available, the cost of these services generally exceeds these women's economic resources.[79]

The risk associated with unsafe abortion is further exacerbated by the fact that women are also often reluctant to seek post-abortion care due to the legal risks and social stigma associated with the procedure.[80] The KNCHR and the Center's reports have revealed that women often fear of harassment by the police and possible prosecution.[81] Also, although the government has clarified that post-abortion care "is legal and not punishable by any part of Kenya laws,"[82] this declaration only offers protection to the health care providers and not to women who seek PAC.[83] Even when they seek PAC, studies indicate that medical personnel, particularly nurses, are inadequately trained in post-abortion care, so women suffering from complications may have to wait an extended period of time for a trained doctor or other medical professional to attend to their needs.[84] Women who seek PAC may also be humiliated by medical staff who make them feel like criminals instead of patients, insult them, and shame them for having undergone abortion.[85] In some cases, medical staff may even be unaware that providing post-abortion care is legal.[86] Further, having their medical history recorded can expose women to harassment by law enforcement officials and family members,[87] a predicament medical staff use to extort bribes from patients.[88]

(c) Lack of access to family planning information and services

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 girls and boys."[89] However, according the 2009 KDHS, Kenya's contraceptive prevalence rate (CPR) is only 45.5%, [90] a mere 6.2% increase from the numbers reported in 2003.[91] For women aged 15 to 24 the CPR is much lower, at 14.1%.[92] 25% of women aged 15 to 49 have an unmet need for contraception.[93]

This low rate of contraceptive usage is largely due to the barriers to women's and girls' access. Many public health facilities face a profound shortage of contraceptives.[94] In many cases, a woman's preferred method of contraception may be unavailable.[95] For many women, 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.[96] Community and familial attitudes and opinions towards contraception have also prevented some women from accessing contraceptives that would otherwise be available to them.[97] This is particularly problematic for adolescents as most face a social stigma and discrimination if they attempt to access family planning services.[98] Young people in Kenya also lack formal and comprehensive sex education, and as a result many are misinformed about their reproductive health including using contraceptives.[99] This leads to a higher incidence of unplanned and unwanted pregnancies.[100]

2. SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

Even though there is underreporting, data from different sources show that violence against women, sexual and otherwise, is prevalent in Kenya. In 2012, a survey concluded that nearly one in three girls in Kenya experience sexual violence before they reach the age 18.[101] As recently as March 2013, the Gender Minister reported that 32% of females in Keya have experienced sexual violence.[102] The 2009 KDHS, shows that 45% of women aged 15 to 49 have experienced sexual or physical violence.[103] Although the domestic legal framework in Kenya provides a mechanism for addressing violence against women and girls,[104] this framework has a number of gaps, and women mostly lack access to the services provided in the policies. For instance, there is no legislation dealing with domestic violence and marital rape.[105] The use of legal procedures is intimidating for women while legal aid is not easily accessible.[106] The different policies that address sexual violence are not implemented at many health facilities and health workers lack adequate training and may not be aware of the existence of these policies.[107] At the community level, police often respond to reports of sexual violence by subjecting survivors to humiliating interrogations and requests for bribes.[108] Although designated 'Gender Desks' were established at many police stations to assist victims of gender based violence, poor equipment, infrastructure, weak investigation and poor training have combined to undermine their effectiveness.[109] A lack of awareness of the availability of post-rape services is another barrier to access to remedies by survivors.[110] When survivors seek out post-rape services, they face a number of obstacles, including poor treatment by police and health care providers.[111] Although emergency contraception is supposed to be provided, religious institutions often refuse to supply it and it is frequently out of stock at other institutions.[112] On the whole, post-rape services are inadequate to meet the needs of victims of sexual violence.[113]

3. COOPERATION WITH INTERNATIONAL MECHANISMS

As mentioned, Kenya has ratified a number of international and regional human rights instruments. On signing the ICESCR, however, Kenya placed a reservation against Article 10(2)[114] which requires that states make provision for paid maternity leave.[115] Despite the urging of the CESCR, Kenya has not yet withdrawn this reservation.[116] However, under the Employment Act of 2007, women in Kenya are entitled to three months maternity leave with full pay.[117] Furthermore, denying women paid maternity leave is contrary to Article 27 of the Constitution, which provides that men and women have the right to equal treatment including the right to equal opportunities in political, economic, cultural and social spheres.[118] Further, Kenya has not signed the optional protocol to CEDAW, which recognizes the competence of the CEDAW Committee to hear individual complaints or institute investigations into breaches.[119] It has also signed but not ratified Optional Protocol II of the CRC, which provides additional rights of protection from child trafficking, pornography and prostitution.[120]

4. QUESTIONS

We hope that the Human Rights Council will consider addressing the following questions to the government of Kenya:

(a) What steps are being taken to allocate the resources necessary to improve maternal healthcare services through ensuring that healthcare facilities are adequately equipped and, to increase the number of skilled healthcare providers?

(b) What measures is Kenya taking to ensure that there are sufficient resources to properly implement the free maternal health care program? How is the Government going to

ensure that hospitals are equipped to deal with the increased number of women seeking maternal health care services?

(c) What concrete measures is the government going to take to improve the training of healthcare providers about patients' rights and eliminate the abuse and neglect of women by medical and hospital staff? What steps are being taken to protect women and girls from gender-based violence and abuse in healthcare facilities? How does the government propose to ensure that women are able to report and seek redress for such abuses?

(d) What measures is the government undertaking to clarify its laws on abortion and ensure that women have access to legal, safe abortion and post-abortion services? What measures is the government taking to implement the 2013 recommendation of the CAT that Kenya "amend its legislation, in order to grant women who have been subjected to rape or incest the right to abortion, independent of any medical professional's discretion."?

(e) What measures does the government plan to undertake to remove the barrier women and girls face in accessing contraceptive services including by ensuring that they have access to comprehensive reproductive health information and services.

(f) What measures will Kenya take to ensure that victims of sexual violence have access to necessary support services, including medical and legal resources? How will the government ensure that health care professionals and police handle cases of sexual violence in a manner that is sensitive to the needs of victims?

5. RECOMMENDATIONS

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

(a) The Government should take measures to reduce the high rate of maternal mortality and improve access to maternal health information and services. Such information should also be available in Kiswahili.

(b) The Government should take steps to ensure that free maternal services declaration is being adequately implemented by allocating sufficient funds to ensure that hospitals that provide maternal care are sufficiently staffed and stocked with crucial supplies to ensure that women receive appropriate care.

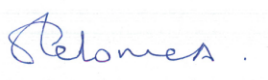
(c) The Government should prevent and remedy abuse, and ensure that health workers adopt an approach that is respectful of clients, which will lead to improved access to quality health care.

(d) The Government should clarify the law on abortion and ensure that women have access to legal, safe abortion and post-abortions services. The Government should implement the CAT's 2013 recommendation, 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.

(e) The Government should take immediate steps to ensure that the health care professionals and police treat women who report sexual or physical violence with respect, and provide them with the necessary medical and legal services.

We hope this information is useful during the Universal Period Review of the Kenyan government's compliance with its human rights violations. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



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[1] International Covenant on Civil and Political Rights (ICCPR), *adopted* Dec. 10, 1948, 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 (*entered into force* Mar. 23, 1976) (*acceded* May 1, 1972) [hereinafter ICCPR]; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) *adopted* Dec. 18, 1979, 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 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), *adopted* Dec. 10, 1984, 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 (*entered into force* June 26, 1987) (*acceded* Feb. 21, 1997) [hereinafter CAT]; Convention on the Rights of the Child (CRC), *adopted* Nov. 20, 1989, art. 24, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess.. Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC]; International Covenant on Economic Social and Cultural Rights (ICESCR), *adopted* Dec. 16, 1966, arts. 3, 6, 23, 26, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6313 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]. African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, arts. 3, 16 O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified* Jan. 23, 1992); African Charter on the Rights and Welfare of the Child, *adopted* July 11, 1990, arts. 14, 16, 21, 27, O.A.U. Doc. CAB/LEG/24.9/49 (*entered into force* Nov. 29, 1999) (*ratified* July 25, 2000) [hereinafter Children's Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003,Doc CAB/LEG/66.6 (2000) (*entered into force* Nov. 25, 2005, (*ratified* Oct. 13, 2010).

[2] CONSTITUTION, art. 26(4) (2010) (Kenya) [hereinafter CONSTITUTION]. The ratification of treaties in Kenya is governed by the Ratification Act. Treaties entered into prior to December 14, 2012 are enforceable in Kenya without the need to comply with the procedures of the Ratification Act. *The Treaty Making and Ratification Act, No. 45* (2012), Kenya Gazette, § 3(1) (Date of Assent: 13th Dec. 2012; Date of Commencement: 14th Dec. 2012) ("This Act applies to treaties which are concluded by Kenya after the commencement of this Act."). Thus, all the treaties in n. 1 are part of the law in Kenya.

[3]WORLD HEALTH ORGANIZATION, *Maternal Mortality Ratio*, http://www.who.int/healthinfo/statistics/indmaternalmortality/en/ (last visited May 22, 2014).

[4] NATIONAL BUREAU OF STATISTICS [KENYA], KENYA DEMOGRAPHIC AND HEALTH SURVEY 2008-09 272 (2010), *available at* http://dhsprogram.com/pubs/pdf/FR229/FR229.pdf [hereinafter KDHS 2008-09].

[5]*See, e.g.*, Committee on Economic Social and Cultural Rights, *General Comment No. 14: The Right to The Highest Attainable Standard of Health (Art. 12)*, (22nd Sess., 2000) *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at paras. 37, 36, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter CESCR, *Gen. Comment 14*]; Committee on the Elimination of Discrimination against Women), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999) *in* Compilation of General Comments and General Recommendation Adopted by Human Rights Treaty Bodies, at para. 27, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) (2004) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

[6] *See, e.g.*, CEDAW Committee, *Concluding Observations: Belize*, para. 27, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Colombia*, para. 393, U.N, Doc A/54/38 (1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 337, U.N. Doc A/53/38 (1998).

[7] CEDAW Committee, *Gen. Recommendation No. 24*, *supra* 5 at 358, para. 11.

[8] CESCR, *Gen. Comment No 14*, *supra* 5 at 78, para. 8.

[9] *Id.*

[10] WHO, UNICEF, UNFPA & THE WORLD BANK, TRENDS IN MATERNAL MORTALITY: 1990-2010 34 (2012), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

[11] KDHS 2008-09, *supra* note 4 at 273.

[12]GUTTMACHER INSTITUTE, *Abortion and Unintended Pregnancy in Kenya*, FACT SHEET (2012), *available at* www.guttmacher.org/pubs/FB_Abortion-in-Kenya.pdf [hereinafter GUTTMACHER FACT SHEET 2012].

[13] UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT 28-29 (2013), *available at* http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2013/English2013.pdf. The reduction of maternal

mortality has also been a key goal at several recent international conferences. *See e.g.*, *Beijing Platform for Action, Fourth World Conference on Women*, para. 107(i), Beijing, China, Sept. 15, 1995, U.N. Doc. A/CONF.177/20 (1995), *available at* http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en; *Programme of Action of the International Conference on Population and Development*, para. 8.21, U.N. Doc. A/CONF.171/13/Rev.1 (1995), *available at* www.un.org/popin/icpd/conference/offeng/poa.html.

[14] CEDAW Committee, *Concluding Observations: Kenya*, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); ESCR Committee, *Concluding Observations: Kenya*, para. 32, U.N. Doc. E/C 12/KEN/CO/1 (2008), *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/456/03/PDF/G0845603.pdf?OpenElement; CRC Committee, *Concluding Observations: Kenya*, paras. 47(a) - (b), 48(a) - (b), U.N. Doc. CRC/C/KEN/CO/2 (2007) *available at* http://www.unhcr.org/refworld/pdfid/4682102b2.pdf; CRC Committee, *Concluding Observations: Kenya*, para. 43, U.N. Doc. CRC/C/15/Add.160 (2001), *available at* http://www.unhcr.org/refworld/pdfid/3cbbe1844.pdf.

[15] CEDAW Committee, *Concluding Observations: Kenya*, para 38(b), U.N. Doc. CEDAW/C/KEN/CO/7 (2011), *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/418/57/PDF/G1141857.pdf?OpenElement; ESCR Committee, *Concluding Observations: Kenya*, para. 32, U.N. Doc. E/C 12/KEN/CO/1 (2008); CRC Committee, *Concluding Observations: Kenya*, para. 48(b)(c), U.N. Doc. CRC/C/KEN/CO/2 (2007); CRC Committee, *Concluding Observations: Kenya*, para. 44, U.N. Doc. CRC/C/15/Add.160 (2001).

[16] *Antenatal Care (at least 4 visits)*, WORLD HEALTH ORGANIZATION, http://www.who.int/gho/urban_health/services/antenatal_care_text/en/ (last visited Jun. 12, 2014).

[17] KDHS 2008-09, *supra* note 4 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.

[18] *Id.* at xxi.

[19] *Id.* at 124.

[20] *Id.*

[21] 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 [hereinafter NATIONAL REPRO. HEALTH POLICY 2007].

[22] NATIONAL REPRO. HEALTH POLICY 2007 *supra* note 21 at 11.

[23]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 (Nov. 10, 2009); National Repro. Health Policy 2007 *supra* note 22 at 11.

[24] MINISTRY OF MEDICAL SERVICES & MINISTRY OF PUBLIC HEALTH AND SANITATION, KENYA *HEALTH POLICY 2012-2030*, 34, *available at* http://www.health.go.ke/images/stories/downloads/kenya%20health%20policy.pdf.

[25] 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 128-140 (2005) [hereinafter POPULATION AND DEVELOPMENT SURVEY 2004]. 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.

[26] 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 ON WOMEN'S HUMAN RIGHTS IN KENYAN HEALTH FACILITIES 26 (2007), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf [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 REPORT 2012].

[27] FAILURE TO DELIVER, *supra* note 26 at 7; KNCHR REPORT 2012, *supra* note 26 at 31.

[28] FAILURE TO DELIVER, *supra* note 26 at 28; KNCHR REPORT 2012, *supra* note 26 at 31.

[29] FAILURE TO DELIVER, *supra* note 26 at 36-37.

[30] *Id.* at 28-29, 33-34.
[31] *Id.*
[32] *Id.*
[33] *Id.* at 35.
[34] *Id.*
[35] *Id.* at 28 (*cited* Focus group discussion with unnamed participant, Nairobi, Feb. 9, 2007).
[36] *Id.*
[37] *Id.*
[38] *Id.* at 18.
[39] Petition No. 562, High Court of Kenya at Nairobi Constitutional and Human Rights Division 7-9 (2012) [hereinafter Petition No. 562].
[40] *Id.* at 21.
[41] *Id.* at 24.
[42] *Id.*
[43] *Id.* at 26.
[44] FAILURE TO DELIVER, *supra* note 26 at 51; *also see* Gabe Joslow, *Women Detained at Kenyan Maternity Hospital Demand Justice*, VOICE OF AMERICA (June 13, 2014), http://www.voanews.com/content/women-detained-at-maternity-hospital-in-kenya-demand-justice/1562030.html.
[45] FAILURE TO DELIVER, *supra* note 26 at 52.
[46] *Id.* at 52-53.
[47] *Id.* at 53-54.
[48] *Id.* at 56.
[49] Petition No. 562, *supra* note 39 at 45.
[50] FAILURE TO DELIVER, *supra* note 26 at 63.
[51] *Id.* at 72-73.
[52] *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.
[53] *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 2013].
[54] 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: 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; AFRICAN SUMMIT ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES, ABUJA DECLARATION ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES 5 Apr. 27, 2001, *available at* http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.
[55] 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 2013, *supra* 54 at 6.
[56] 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*].
[57] Bungoma Petition, In the High Court of Kenya at Bungoma, 6 (2014) (on file with the Center for Reproductive Rights) [hereinafter Bungoma Petition].
[58] Owino: *Not so Free*, *supra* note 56 at 1, 4.
[59] *Pregnant Woman Forced to Give Birth While Standing in Nyeri Hospital*, STANDARD MEDIA, http://www.standardmedia.co.ke/ktn/video/watch/2000074070/-pregnant-woman-forced-to-give-birth-while-standing-in-nyeri-hospital (last visited June 13, 2014).
[60] Bungoma Petition, *supra* note 57 at 4.
[61] Ministry of Health, Kenya, *National Post Abortion Care Curriculum for Service Providers xii* (undated). (A foreword by the Director of Medical Service, Ministry of Health). Unsafe abortion contributes to the high maternal mortality rate in Kenya: GUTTMACHER FACT SHEET 2012, *supra* note 13.
[62] CONSTITUTION, *supra* note 2, art. 26(1)(4).
[63] The Penal Code, (2009) Cap. 63 §§ 158-160 (Kenya).

[64] MINISTRY OF HEALTH AND SANITATION, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 21 (2nd ed., 2009), *available at* http://www.svri.org/nationalguidelines.pdf.
[65] United Nations 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), *available at* http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhstazfkB2WLZhxlPrVe5TzqPmNdc3Tjjfm9%2bwrAJyt9x3Q0Ds3Vu13baS8lK%2bxy1aSSq8%2fQkP6lJl6MjvRPlU%2b6Yg0BciFe%2fLL9uklEp9AP7m [hereinafter UNHRC Report: Kenya (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).").
[66] CRC Committee, *Concluding Observations: Kenya*, 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 … .").
[67] CEDAW Committee, *Concluding Observations, Kenya*, para. 37-38, U.N. Doc CEDAW/C/Ken/CO/6 (2007) ("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.").
[68] COMMITTEE AGAINST TORTURE, CONCLUDING OBSERVATIONS ON THE SECOND PERIODIC REPORT OF KENYA, ADOPTED BY THE COMMITTEE AT ITS FIFTIETH SESSION para. 28 (2013), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/crr_Concluding_Observations_Kenya_May13.pdf.
[69] 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*, 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/6 (2007; COMMITTEE AGAINST TORTURE, CONCLUDING OBSERVATIONS ON THE SECOND PERIODIC REPORT OF KENYA, ADOPTED BY THE COMMITTEE AT ITS FIFTIETH SESSION para. 28 (2013); CRC Committee, *Concluding Observations: Kenya*, 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/6 (2007).
[70] KNCHR REPORT 2012, *supra* note 26 at 47.
[71] *Id.* at 66-67.
[72] GUTTMACHER FACT SHEET 2012, *supra* note 13.
[73] *Id.*
[74] *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.
[75] GUTTMACHER FACT SHEET 2012, *supra* note 13.
[76] WORLD HEALTH ORGANIZATION, MATERNAL MORTALITY IN 2005: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, AND THE WORLD BANK 25 (2007), *available at* http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf (According to this publication, Kenya has 7,700 maternal deaths per year; according to the Ministry of Health and the Kenya Demographic and Health Survey 1998, 35% of pregnancy related mortality is attributable to unsafe abortion).
[77] FAILURE TO DELIVER, *supra* note 27 at 24-25: Half of the women treated by a hospital for complications from unsafe abortion were under the age of 20.
[78] GUTTMACHER INSTITUTE, *Abortion and Unintended Pregnancy in Kenya*, IN BRIEF 3 (2012), *available at* http://www.guttmacher.org/pubs/IB_UnsafeAbortionKenya.pdf. [hereinafter GUTTMACHER IN BRIEF 2012].
[79] *Id.* 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."); CENTER FOR REPRODUCTIVE RIGHTS, IN HARM'S WAY: THE IMPACT OF KENYA'S RESTRICTIVE ABORTION LAW 59-60 (2010), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/InHarmsWay_2010.pdf [hereinafter IN HARM'S WAY].
[80] FAILURE TO DELIVER, *supra* note 27 at 25.

[81] *See* KNCHR REPORT 2012, *supra* note 26 at 49-59; IN HARM'S WAY, *supra* note 79 at 76.
[82] NATIONAL POST ABORTION CARE CURRICULUM FOR SERVICE PROVIDERS: TRAINEES HANDBOOK 1-24, *available at* https://intranet.reprorights.org/GLP/Resources/MOH%20-%20National%20PAC%20Curriculum%20for%20Service%20Providers.pdf.
[83] *Id.* The training manual provides that "[c]omprehensive PAC is a life-saving procedure that should be available to all women and provision of comprehensive post-abortion care does not lead to punishment or withdrawal of registration of the service provider." It does not, however, address the issue of women fearing to seek PAC for fear of prosecution.
[84] GUTTMACHER IN BRIEF 2012, *supra* note78 at 2. IN HARM'S WAY, *supra* note 79 at 88-90.
[85] FAILURE TO DELIVER, *supra* note 27 at 25; IN HARM'S WAY, *supra* note 79 at 92-93.
[86] IN HARM'S WAY, *supra* note 79 at 76-78 (noting further that fears of prosecution are not unfounded despite the legality of the treatment).

[87] FAILURE TO DELIVER, *supra* note 27 at 25.

[88] IN HARM'S WAY, *supra* note 79 at 90-92.
[89] CEDAW Committee, *Concluding Observations: Kenya*, Para XX U.N. Doc. CEDAW/C/KEN/CO7 (2011).
[90] KDHS 2008-09, *supra* note 4 at 61.
[91] MINISTRY OF HEALTH, NATIONAL FAMILY PLANNING COSTED IMPLEMENTATION PLAN 2012-2016 (2013), *available at* http://www.fhi360.org/resource/national-family-planning-costed-implementation-plan-kenya.
[92] *Id.* at 3.
[93] Maura Graff, *Family Planning Is a Crucial Investment for Kenya's Health and Development*, *available at* http://www.prb.org/Publications/Articles/2012/kenya-family-planning.aspx.
[94] 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/.
[95] IN HARM'S WAY, *supra* note 79 at 44-45.
[96] *Id.*
[97] For example, women report their husbands becoming angry and intervening when they began using contraceptives: UNFPA, *Family Planning in Kenya: Not for Women Only*, Jul. 1, 2009, *available at* http://www.unfpa.org/public/News/pid/3015.
[98] 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 79 at 46.
[99] *Id*. at 47
[100] *Id*. at 47-48.
[101] Katy Migiro, *One third of Kenyan girls subjected to sexual violence – survey*, TRUSTLAW (*accessed* Jun. 12, 2014), http://www.trust.org/trustlaw/news/one-third-of-kenyan-girls-subjected-to-sexual-violence-survey.
[102] Lillian Onyango, *Fight against sexual violence in Kenya 'dimmed'*, DAILY NATION (*accessed* Jun. 6, 2014)
[103] POPULATION AND DEVELOPMENT SURVEY 2004, *supra* note 25 at 1.
[104] CONSTITUTION, *supra* note 2, art. 29 (c), 53 (1) (d). *See* The Sexual Offences Act, (2006) KENYA GAZETTE SUPPLEMENT No. 3, *available* at http://www.urpn.org/uploads/1/3/1/5/13155817/sexual_offences_act_1.pdf.
[105] CEDAW Committee, *Concluding Observations: Kenya*, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011). The Protection Against Domestic Violence Bill 2012 is a positive step forward as it prohibits sexual violence within marriage, but it has not been enacted yet.
[106] POPULATION AND DEVELOPMENT SURVEY 2004, *supra* note 25 at 4.
[107] KNCHR REPORT 2012, *supra* note 26 at 88.
[108] *CK v. Commissioner of Police*, 7, (2013), High Court of Meru (Kenya).
[109] INSTITUTE OF ECONOMIC AFFAIRS, STATUS OF GENDER DESKS AT POLICE STATIONS IN KENYA: A CASE STUDY OF NAIROBI PROVINCE iii 2009, *available at* https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.ieakenya.or.ke%2Fpublications%2Fdoc_download%2F49-status-of-gender-desks-at-police-stations-in-kenya&ei=ZzibU9PEH8_ksAT_qYKYBA&usg=AFQjCNFuk6TeCNmv_GKYWzq97FHlqxWElg&bvm=bv.68911936,d.cWc.
[110] KNCHR REPORT 2012, *supra* note 26 at 82.
[111] *Id.*

[112] IN HARM'S WAY, *supra* note 79 at 43-45.
[113] *Engendering Health Sector Responses to Sexual Violence and HIV in Kenya: Results of a Qualitative Study* Vo.20 AIDS CARE: PSYCHOLOGICAL AND SOCIO-MEDICAL ASPECTS OF AIDS/HIV 2, 2 (2008), *available* at http://peer.ccsd.cnrs.fr/docs/00/51/34/28/PDF/PEER_stage2_10.1080%252F09540120701473849.pdf.
[114] A reservation to a treaty is a limitation of the commitment undertaken. *See* Vienna Convention on the Law of Treaties art. 19, May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679 (*entered into force* Jan. 27, 1980), *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf.
[115] ICESCR, *supra* note 1. (While the Kenya Government recognizes and endorses the principles laid down in paragraph 2 of article 10 of the Covenant, the present circumstances obtaining in Kenya do not render necessary or expedient the imposition of those principles by legislation).
[116] CESCR, *Concluding Observations: Kenya*, U.N. Doc. E/C. 12/KEN/CO/1 (2008).
[117] Employment Act, THE LAWS OF KENYA, Cap. 226 art. 29, National Council for Law Reporting (2012), *available at* http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/EmploymentAct_Cap226-No11of2007_01.pdf.
[118] *VMK v. Catholic University of Eastern Africa (CUEA),* Industrial Court of Kenya in Nairobi, Cause no. 1161 of 2010, Nov. 8, 2013. *Summary available at* http://kelinkenya.org/wp-content/uploads/2013/11/26112013-Case-Summary.pdf.
[119] KNCHR REPORT 2012, *supra* note 26 at 85.
[120] Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography 227 Doc. A/RES/54/263; C.N.1032.2000 (May 25, 2000).