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Report on Kenya's Compliance with its Human Rights Obligations on

Sexual and Reproductive Health and Rights

Submitted by:

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INTRODUCTION

In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the "Center"), the Federation of Women Lawyers – Kenya (FIDA-K), Trust for Indigenous Culture and Health (TICAH) , Network for Adolescent and Youth of Africa (NAYA) and Kenya Female Advisory Organization (KEFEADO) jointly submit this letter to supplement the report of the government of Kenya, scheduled for review by the Human Rights Council during its 35th session of the Universal Periodic Review Working Group (2020). The Center for Reproductive Rights (the Center) is a nonprofit legal advocacy organization dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at the national, regional, and international levels to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfill. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in 45 nations in Africa, Asia, Europe, and Latin American and the Caribbean, the United States, and through in-depth engagement with UN and regional human rights bodies. The Federation of Women Lawyers – Kenya is a non-profit, membership organization consisting of over 1,100 women lawyers committed to increasing

women's access to justice in both formal and informal justice systems in Kenya. It works to promote women's individual and collective power to claim their rights in all sphere of life. TICAH is a non-governmental organization that promotes health. NAYA aims at enhancing the capacity of youth advocates, young people, youth led organizations and policy makers to undertake sexual and reproductive health and rights advocacy at international, regional, national and counties in Kenya to improve the quality, affordability and accessibility of health including sexual and reproductive health and rights information and services. KEFEADO is a non-governmental organization that promotes gender equity, equal opportunities and human rights for all with a focus on engaging and questioning cultural beliefs and practices towards building rights-based cultures, as well as building girls, female youth and women's leadership.

Kenya is a party to multiple international and regional human rights treaties that require state parties to ensure the sexual and reproductive health and rights of women and girls.[1]At the national level, Kenya has enacted various laws and adopted policies that guarantee sexual and reproductive health and rights of women and girls.[2] Despite the existence of strong legal framework, women and girls continue to face numerous reproductive rights violations. This letter highlights the various reproductive issues that we urge and hope the Human Rights Council (HRC) will consider during its review of Kenya: (i) Maternal mortality and inadequate access to maternal health care (ii) Inadequate access to family planning information and services (iii) High rate of unsafe abortions and inadequate access to post-abortion care

A. Maternal mortality and Inadequate access to maternal health care

1. Kenya's maternal mortality rate (MMR) remains high. According to the World Health Organization's (WHO) 2015 report Kenya's MMR had only decreased by 1.2% per year since 1990.[3] 510 women and girls out of every 100,000 live births, die,[4] which is an increase from the MMR documented in the same WHO report covering previous years.[5]

2. During the 2015 UPR review, Kenya committed to adhere to "*WHO standards on health service delivery"*[6] and guarantee *"gender equality and women's rights including sexual and reproductive rights"*[7] Further the government committed to *"implement the reproductive health strategy 2009-2015."*[8]

3. In 2016, the Committee on Economic and Social Cultural Rights (CESCR Committee) raised its concerns over high rates of maternal mortality in Kenya.[9] CESCR Committee recommended that the government takes *"concrete measures to ensure free maternal health-care services and to prevent the incidence of post-delivery detention in health-care facilities"*[10] Similarly, in 2017, the Committee on Elimination of all Forms of Violence against Women (CEDAW Committee), raised its concern over high rates of maternal mortality and morbidity in Kenya.[11] The CEDAW Committee recommended that the government of Kenya *"strengthens efforts to reduce the high maternal mortality rate, and ensure access for all women, including women with disabilities, those in prostitution to health-care facilities and medical assistance by trained personnel, especially in rural areas*". [12] The CEDAW Committee further recommended *"an increase of human, technical and financial resources allocated to the implementation of the free maternity care policy and establish awareness-raising programmes and ensure implementation of same".*[13]

4. While there are positive milestones such as the enactment of Health Act 2017 and the Health (Amendment) Act 2018,[14] the piloting of the Universal Health Coverage (UHC) in four counties[15] and the expansion of *Linda Mama* programme to include 700 faith-based health facilities and 2000 private health facilities[16], access to quality maternal health still remains a challenge. Lack of proper policy guidelines, lack of implementation of court decisions, poor quality of services, distance to health facilities, cost of services, detention of women post-delivery due to inability to pay medical bills and inadequate funding remain key barriers to quality maternal health care as demonstrated below.

5. According to the latest Kenya Demographic Health Survey (KDHS, 2014), only 58% of pregnant women attended the WHO recommended four or more antenatal care visits.[17] A woman's geographic location has a significant impact on her access to antenatal care: 68% of women living in urban areas are more likely to attend four or more antenatal care visits compared to 51% of those living in rural areas.[18] Women with higher education and those in a higher wealth quintile are also more likely to attend the recommended antenatal care visits than their counterparts.[19] A more recent study of 564 facilities across Kenya offering at least one maternal care service found that the quality of maternal care is low, especially for antenatal and delivery services.[20] In addition, access to maternal health services by women and girls with disabilities remain a great challenge. Hospitals have reported not having tools that capture data on expectant women with disabilities. This is further compounded by physical inaccessibility of several health facilities and lack of accessible information on provision of quality maternal health services by women and girls with disabilities.[21]

6. Poor quality of care remains a leading contributor to maternal deaths in Kenya. In 2014, the Center filed a petition at the High Court of Kenya challenging the mistreatment and physical abuse of a woman who went to deliver in a government health facility and was forced to deliver on the floor.[22] In 2018, the High Court of Kenya declared that the "physical and verbal abuse meted out on the petitioner during delivery amounted to a violation of the right to dignity and right not to be subjected to cruel inhumane and degrading treatment". The Court also found that the National and County Government had failed to implement and/or monitor the standards of free maternal health care and services, thus resulting in the mistreatment of the petitioner and the violation of her rights.[23] The Court directed and ordered a formal apology to the Petitioner and awarded the petitioner Kshs 2,500, 000 (equivalent of 25000 USD) for infringement of her rights. However, these recommendations are yet to be implemented. According to a 2017 Confidential Enquiry on maternal deaths by the Ministry of Health, 9 out 10 women die due to poor quality of care by health professionals. [24] Additionally, the Enquiry shows that these deaths could have been prevented by improving the care for 88.1% of women who died.[25]

7. The report further shows that 73.3% (355) maternal deaths occurred outside working hours (after 5pm to before 8am), on weekends and public holidays**.** 26.7% (129) died during weekday normal working hours (8am- 5pm).[26] These findings attest to media reports of women and especially those in remote areas dying due to lack of services outside working hours and distance to health facilities.

8. For instance, in 2018 a woman went to deliver in a public health dispensary facility in Kwale County, one of the remotest areas in Kenya. On arrival, they found out that the dispensary had been

closed and nobody to assist. The woman died later while the family sought alternative health facilities where she could deliver.[27] Several factors led to her preventable death including lack of transport and distance to the facility. According to KDHS 2014, distance to health facility is the second leading barrier to women accessing quality maternal health care.[28]

9. Detention of women post-delivery remain pervasive. In 2015, the High Court of Kenya issued a ground-breaking decision on detention of women seeking maternal health services. The court stated that such practices violated women's right to not be deprived of freedom arbitrarily, right to dignity, right to health, right to be free from discrimination and right to be free from inhuman treatment and punishment.[29] The court ordered the Ministry of Health (MoH) to develop clear guidelines and procedures for implementing the waiver system in all public hospitals. The court further ordered MoH and County government of Nairobi to take the necessary administrative, legislative, and policy measures to eradicate the practice of detaining patients who cannot pay their medical bills.

10. These orders are yet to be implemented. To date, several women and especially those from lower socio-economic status continue to be detained post-delivery due to inability to pay medical bills.[30] In March 2019, MoH appeared before the Parliamentary Health Committee to explain the magnitude of detention of patients due to inability to pay medical bills in public and private facilities. According to the MoH's report, out of the 216 health facilities that had provided data, 10 facilities at national and county level reported to be holding 300 patients due to non-payment of medical bills. [31]Among these were 184 patients being detained at Kenya's national referral hospital for approximately Kshs 6 billion (approximately 60,000, 000 million USD) debt.[32] MoH acknowledged that detention of patients due to non-payment is an on-going challenge and reported that a special technical team had been constituted to investigate whether patients being held in confined rooms for non-payment of medical bills.[33] Though MoH had committed to publish the report of the investigations within one month, the report is still not publicly available.

11. Access to skilled medical personnel is fundamental for ensuring safe pregnancy and delivery, as well as for preventing maternal and newborn deaths and related long-term health issues. By 2015, Kenya had 5,660 doctors which translated to approximately 1.5 doctors to 10,000 population, against the WHO recommended minimum staffing level of 36 doctors per 10,000 population.[34] This is aggravated by health professionals' industrial strikes and continuous threats to withdraw services. In December 2016, doctors went on strike for more than 100 days citing low renumeration and lack of proper equipment as adversely affecting their capacity to deliver quality services. This led to withdraw and interruption of key maternal health facilities in certain instances women being forced to deliver outside health facilities and others losing their lives. [35] Similarly, on June 5, 2017, nurses went on a national strike for over 150 days demanding a pay rise. [36] Despite government reaching an agreement with doctors and nurses, there is a lot of uncertainty with the health professionals threatening to withdraw services from time to time.[37]

12. Further, lack of clarity on implementation of *Linda Mama* programme and UHC creates uncertainty on implementation of certain components of maternal health care such as ante natal and post-natal services. In 2013, when the *Linda Mama* programme was introduced through a presidential directive, free maternity funds were being channeled to the county governments as reimbursements

for services offered. However, in 2016, the national government, through the MoH, introduced the *Linda Mama* programme, whereby funds to cater for free maternity are paid through the National Health Insurance Fund (NHIF). The *Linda Mama* package includes antenatal care, delivery, postnatal care, conditions and complications during pregnancy and outpatient care services for the infant for a period of one year. To benefit from this programme, women have to register with the NHIF.[38] However, due to lack of adequate information and clarity of services provided, majority of women especially those in rural areas rarely register thus missing this crucial benefit. Additionally, women have reported that post-delivery complications are not adequately covered and that they are forced to pay out of their pockets.

B. Abortion and Post Abortion Care

13. During the last UPR review in 2015, various states recommended to the government of Kenya to *"ensure that women have access to legal and safe abortions, especially in cases of pregnancies resulting from rape or incest"*.[39] In 2016, the CESCR Committee raised its concerns over criminalization of abortion under the Penal Code and recommended to the government of Kenya[40] to *"amend legislation on the prohibition of abortion in order to render it compatible with other fundamental rights, such as women's rights to health, life and dignity, and reinstate the Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya"*[41]. Similarly, the Committee on the Rights of the Child (CRC Committee) raised its concerns over "the high rates of maternal mortality among adolescents, including due to unsafe abortions, and the impact of restrictive abortion laws that contributed to undermining adolescents' access to safe and legal abortion and post-abortion care". [42] In its recommendations, the CRC Committee urged the government to *"decriminalize abortion in all circumstances and review its legislation with a view to ensuring that girls have access to safe abortion and post-abortion care services and that their views are always heard and respected in abortion decisions and provide clear guidance to health practitioners and information to adolescents on safe abortion and post-abortion car"*. [43]

14. Further, in 2017, the CEDAW committee expressed its concern on high maternal mortality rates due to unsafe abortion and Kenya's restrictive and unclear legal framework on abortion..[44] The CEDAW Committee recommended *"amendment of the Penal Code to decriminalize abortion in all cases, and legalization of abortion, at least in cases of rape, incest, severe foetal impairment, and risk to the health and/or life of the pregnant woman and ensure access to quality post-abortion care, especially in case of complications resulting from unsafe abortions"*[45] The CEDAW Committee further recommended to Kenya to *" reinstate the Standards for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya of 2012"*[46]

15. Unsafe abortion is one of the leading contributors to high maternal mortality rates in Kenya. According to the most recent study by the African Population and Health Research Center (APHRC) and the Ministry of Health (MoH) about half a million induced abortions occurred in the country in 2012. Most of these abortions were unsafe and resulted in various complications. The laws governing abortion in Kenya remain confusing and contradictory. While Kenya's 2010 Constitution provides for abortion in situations where a woman's life or health is at risk,[47] the Penal Code has not been revised to reflect this change.[48] 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."[49] Even though this statement was removed from the main text of the guideline during its revision in 2014, the new guideline still provides, in its annex, 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."[50]

16. The Ministry of Health made the confusion surrounding the legality of abortion worse by withdrawing its 2012 *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya*, which provided guidance to medical professionals as to when they could perform abortion services under the 2010 Constitution.[51] In addition, in 2014, the Ministry of Health issued a memo to all health care providers stating that "abortion on demand is illegal" without clarifying the legal exception under the Constitution.[52] The memo further stated that it is illegal for health workers to participate in trainings on either safe abortion care or the use of the drug Medabon for medical abortion.[53] The memo threatened health workers with legal and professional sanctions, even though trainings are essential to the development of health workers' skills in comprehensive and life-saving abortion care.

17. In June 2015, the Center and FIDA filed a case in the High Court of Kenya that challenged the Ministry of Health's memo and the withdrawal of the Standards and Guidelines. The objective of the case was to ensure that the Standards and Guidelines are reinstated so that there is certainty around access to and provision of legal and quality abortion and post-abortion care services in Kenya as well as to ensure that persons mandated to undertake abortions are able to be trained in order to know how to carry out safe abortions. The 1st Petitioner, on whose behalf her guardian was suing the State, is a girl who was sexually abused, underwent an unsafe abortion, was unable to access post- abortion care and suffered physical and emotional harm. Unfortunately, the girl died in 2018 due to the lifelong complications as result of the unsafe abortion.

18. On 12th June 2019, the High Court of Kenya delivered a judgment on the case and declared that the right to health, life, non- discrimination, consumer rights, information and right to scientific progress of women and girls of reproductive age had been infringed upon and threatened by the actions of MOH.[54] The Court further declared that MOH violated the rights to information, expression and association and the right to scientific progress of the health providers by its action of banning trainings on abortion, that the directive banning training of health professionals on abortion and the Memo withdrawing standards and guidelines on abortion are unlawful, illegal, arbitrary and null and void.[55] Additionally, the Court quashed the directive and letter thereby reinstating the standards and guidelines, and training of health professionals on abortion in accordance with the Constitution.[56] With regards to victims of sexual violence, the court declared that if in the opinion of a trained health professional a pregnancy resulting from rape and defilement poses a danger to the life or health, including mental health, of a pregnant woman, the pregnant woman is entitled to an abortion. [57] The Court also awarded PKM, the mother of the deceased minor, JMM, 3 million shillings (approx. USD 30,000) for mental and emotional harm caused by suffering of JMM and ordered the government to pay the damages.[58] Despite this being a groundbreaking decision, some sectors have expressed dissatisfaction and notices of intentions to appeal have been filed.

19. While this decision clarifies circumstances under which abortion should be provided, increased attacks by opposition groups have contributed to closing civic space for SRHR advocates and institutions, and increased abortion stigma thus adversely affecting access to abortion and post abortion care services and information. For instance, in August 2018, Marie Stopes Kenya embarked on a nine-week public awareness campaign on comprehensive reproductive health services undertaken to among other things: highlight the statistics and dangers of unsafe abortion; abortion stigma and discrimination of women and girls who have undergone unsafe abortion and directing members of the public in need of pregnancy crisis counselling to call the Marie Stopes Kenya Customer Care Helpline.

20. Three weeks in to the campaign, the Kenya Film Classification Board (KFCB), a state agency that regulates the creation, broadcasting, possession, distribution & exhibition of film and broadcast content, issued a press statement banning the airing of the advertisements. KFCB claimed that the advertisements were promoting abortion on demand specifically by teenage girls contrary to the Constitution of Kenya, 2010. On November 2, 2018, an organization which promotes life, family and religious liberty lodged an official complaint to the ministry of health claiming that Marie Stopes Kenya was advertising abortion services through billboards and Social media contrary to the Constitution of Kenya, 2010. In November 2018, the Kenya Medical Practitioners and Dentist Board (KMPDB) issued a ruling against Marie Stopes Kenya. KMPDB ordered Marie Stopes to immediately cease and desist offering any form of abortion services in all its facilities within the Republic of Kenya and to pull down the 'misleading' information on its website and any other information channels with immediate effect and to ensure that any future information on its website.[59] This is despite the fact that Marie Stopes Kenya has been operating in Kenya since 1985 and its 23 clinics has been a provider of much needed reproductive health services in many communities in Kenya and in some communities, remains the only provider of life-saving reproductive health services including post-abortion care.

21. On 20th November 2018, the MoH, further banned Marie Stopes Kenya from providing any form of post abortion care in all in its facilities within Kenya contrary to National Post abortion Care Reference Manual (2013) and the directive issued by the MoH in June 2013 that post abortion care is an integral part of maternity service. This ban was however lifted in December 2018 following an intense social media campaign by reproductive health advocates and concerned citizens.

22. On November 30, 2018, the Center and NAYA filed a petition at the High Court of Kenya challenging the constitutionality of the decision and its impact on enjoyment of fundamental rights including the right to safe legal abortion. Court hearing of interested parties' applications to be enjoined in the case will hold in July 2019.[60]

23. General Comment no.22 (the General Comment) states that "the dissemination of misinformation and the imposition of restrictions on the right of individuals to access information about sexual and reproductive health also violates the duty to respect human rights".[61] The General comment further states that "national and donor States must refrain from censoring, withholding, misrepresenting or criminalizing the provision of information on sexual and reproductive health, both to the public and

to individuals as such restrictions impede access to information and services and can fuel stigma and discrimination".[62]

24. Abortion stigma and misinformation remains a key barrier to women and seeking legal abortion and post- abortion care services in Kenya. Between 2016 and 2018, the Center held community dialogues on impact of unsafe abortion on women and girls from informal settlements.[63] During the dialogues, women narrated how misinformation and abortion stigma contributed to unsafe abortions. In one instance, an adolescent girl narrated how she was sexually abused by a relative and when she procured an abortion, she was reported to the local administration and was forced to do unpaid work.

25. Further, the increasing opposition on provision of abortion services in Kenya continues to create confusion on a service that is legally provided in the Constitution of Kenya 2010. For instance, in March 2019, 13 billboards were erected in various streets in Nairobi conveying that *"abortion is murder"* and calling for *"shutdown of abortion clinics"* contrary to the Constitution of Kenya, 2010. These messages are not only misleading, but also fuel stigma and discrimination on basis of gender and sex as only women and girls seek these life-saving services. The call for shut down of 'abortion clinics' promotes an illegality by threatening health providers and facilities legally mandated to provide reproductive health services. On April 24, 2019 a coalition of human rights organizations and women from the communities petitioned the County government of Nairobi to pull down the misleading billboards. The billboards were later pulled down. However, in the absence of proper guidelines on advertising rules and regulations similar billboards could be replicated in other areas of the country.

26. Access to post-abortion care (PAC) is essential to protect the health and lives of women—particularly in Kenya where the rate of unsafe abortion and resulting complications remain high. According to APHRC and MoH study on the Cost of PAC in Kenya, in 2012 the government of Kenya spent approximately 432.7 million shillings (approx..US$5.1 million) on PAC.[64] Most was spent in the treatment of severe medical complications. In 2016, the treatment costs for these complications in public facilities was estimated to 533 million shillings (about US$6.3 million).[65]

27. According to a 2018 study conducted in sixteen health facilities in three regions in Kenya, provision of quality PAC in healthcare facilities in Kenya is still low. The study shows that restrictive abortion laws, stigma towards abortion, intermittent service interruptions through industrial strikes and inequitable access to care drive unsafe terminations. [66]The study further indicates, poor PAC service availability and lack of capacity to manage complications in primary care facilities result in multiple referrals and delays in care following abortion, leading to further complications.[67] Additionally, the study reports that uncertainty around legality of abortion led to discrimination of women and girls seeking PAC services at healthcare facilities. Service providers often condemned abortion and discriminated against women who secured abortion and did not always support patients' healthcare needs causing delays in care provision.[68] According to National Post Abortion Care Curriculum for Service Providers PAC "is legal and not punishable by any part of Kenya [sic] laws." Additionally, the MoH has developed PAC guidelines. However, these guidelines are yet to be officially launched and information disseminated to women and girls.

C. Inadequate Access to Family Planning Information and Services

28. In its 2015 UPR review, various states recommended to the government of Kenya to *'intensify its efforts to improve health infrastructure as well as the quality and delivery of health services, including access to reproductive health information and contraceptives for women in marginalized areas'*.[69]The government of Kenya supported this recommendation an indication of its commitment to improve access to family planning information and services by women and girls.

29. In 2016, the CESCR Committee recommended to Kenya to take appropriate measures and *"strengthen its efforts to improve access to sexual and reproductive health information and services, including contraceptives"*. [70] In 2017, the CEDAW Committee recommended *"inclusion of age-appropriate and comprehensive education on sexual and reproductive health and rights, and on responsible sexual behaviour, in school curricula, with special attention to the prevention of early pregnancy and the control of STIs, including HIV/AIDS, ensure access to modern contraceptives for all, including adolescents, and take measures to ensure this information reaches girls who are not in school"*[71]

30. Despite these recommendations, women and girls continue to face significant barriers while seeking family planning and services. A large portion of Kenyan women have an unmet family planning need, but are not currently using a contraceptive method.[72] Although women from all demographic backgrounds have significant unmet family planning needs,[73] the rate of unmet need falls precipitously as wealth increases with a rate of 24% unmet need in the lowest wealth quintile and only about 10% in the highest quintile.[74] In addition, usage disparities are even more pronounced by geographic area[75] due to factors including inequitable regional distribution of contraception and frequent stock outs. For example, only 3.4% of women in the former Northeastern Province —a region with low socio-economic indicators—use contraceptives, whereas 70.4% of women in the former Eastern Province and 72.8% in the former Central Province reported using contraceptives.[76]

31. These disparities in usage rates are due to a variety of barriers to women's and adolescent girls access to family planning information and services. According to a 2018 baseline survey conducted in five counties in Kenya by the Center and TICAH (CRR-TICAH baseline survey),[77] public health facility stock outs, inequitable distribution of contraceptives, and costs associated with procuring contraceptives, such as lost wages or transportation, stigma and lack of accurate and comprehensive information are key barriers to access to family planning services.[78] Further 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 .[79] Moreover, a woman's preferred method of contraception is often unavailable[80] or may be too costly. Women also face negative attitudes and stigma against contraceptive use from family or community members. The patriarchal nature of certain communities in Kenya has forced many women not to have access to family planning services. During the interviews and focused group discussions, women reported that they had to seek permission from their husbands before getting contraceptives. In circumstances where the husband was of contrary opinion, women would be forced to secretly get in to a family planning plan.[81]

32. Misinformation is a leading barrier to access family planning services. During the survey, women and adolescent girls reported inadequate access to accurate and comprehensive information on family planning services. Majority relied on their friends and peers, radio advertisements and health talks at health facilities. In most cases the information was inaccurate and misleading. Some of the myths and misconceptions shared during the interviews included: "family planning methods causes "cancer", "infertility", "mental illness", "severe bleeding" and 'excessive sexual desires". For adolescents and young women, lack of youth and adolescent friendly services meant that they could not access services in main health facilities.

33. This is exacerbated by lack of formal and comprehensive sexuality education (CSE), stigma on adolescent SRHR, lack of implementation of policies and restrictive legislative framework. For instance, one of the key objectives of the National Adolescent Sexual and Reproductive Health Policy is to *"contribute to increased access to ASRH information and age appropriate comprehensive sexuality education (AACSE)"*.[82] Kenya has also signed on to the Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013). Despite this framework, Kenya is yet to implement a comprehensive sexuality curriculum. This is due increased opposition specifically from religious organizations and misconceptions on CSE. Subsequently teenage pregnancies have been on the rise leading to increased school dropouts. According to the 2014 DHS, about 20% of girls between the ages of 15-19 in Kenya have had at least one child.[83] Adolescent girls from lower income levels are more likely to have begun childbearing than their wealthier counterparts, as are adolescents who do not complete primary or secondary school.[84]

34. Additionally, restrictive laws such as the Sexual Offences Act 2006 which criminalize non-coercive sex between adolescents continue to fuel stigma around adolescent SRHR thus affecting adolescent's ability to access CSE. Further the criminalization disproportionately affects adolescent boys who have been imprisoned for having non-coercive sex with adolescent girls of similar age and maturity.[85]

35. Women and girls with disabilities face multiple challenges and discrimination while seeking family planning services and information. For instance, CRR-TICAH baseline survey established that women and girls with disabilities rarely sought reproductive health services in health facilities. This is mainly due to stigma against women and adolescent with disabilities, informed by the perception that they do not have sexual desire and therefore do not take part in sexual relations, related to which they would need to protect themselves from infections or prevent pregnancies.[86] Further lack of information in accessible formats hinders women and adolescents with disabilities from seeking family planning services. For instance, during the study, it was established in several health facilities information is usually disseminated in print form. Most public health facilities reported that they lacked alternative modes of communication such as sign language, plain language for people with intellectual disabilities and audio messages for the visually impaired.

D. Recommendations

We hope the Council will consider the following recommendations to the government of Kenya.

i. Government should take measures to ensure access to quality maternal health services by all women. Specifically, government should end detention of women post-delivery due in ability to pay medical bills and clarify the maternity benefit package under *Linda Mama Programme* and the Universal Health Coverage programme;

ii. Government should take steps to ensure that women and adolescent girls, including those in rural areas, those of low income, and those with disabilities have access to comprehensive information on the full range of family planning and contraceptives and that they also have access to affordable family planning and contraceptive services including emergency contraceptives;

iii. Government must ensure access to dignified and quality care by women seeking maternal health services. Such measures should include training of health professionals' patients' human rights and ensuring that facilities adopt a rights-based approach to delivery of maternal health services;

iv. Government must end violence against while seeking maternal health services, hold those who violate their rights accountable, and establish/ strengthen complaints mechanisms within facilities to allow reporting of mistreatment while seeking maternal health services;

v. Government should reinstate training of all nurses, clinical officers, midwives and doctors on provision of safe and legal abortion services in accordance with the Constitution of Kenya and the High Court of Kenya judgement on Petition 266 of 2015;

vi. Government should avail in all facilities trained health professionals, essential medicines and equipment for safe and legal abortion in accordance with the Constitution of Kenya and the High Court of Kenya judgement on Petition 266 of 2015;

vii. Government should ensure redress and appropriate remedy to victims of reproductive rights violations. To this end, government must compensate PKM 3 million shillings (approx. USD 30,000) in line with the judgement on Petition 266 of 2015;

viii. Government should take measures to end misinformation by private actors and ensure that actors are held accountable for their actions;

ix. Government should decriminalize non-coercive sex between adolescents, review the Sexual Offences Act 2006 and introduce a close in age exception to section 8 (1) and 11 (1) of the Act.

x. Government should increase proportion of public health facilities providing comprehensive youth friendly services from 10% to 30% by 2020 in line with The National Adolescent and Youth Friendly Services Guidelines.

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

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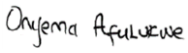

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[1] See ratification status at <https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=90&Lang=EN >
[2] Constitution of Kenya 2010, the National Adolescent Sexual and Reproductive Health Policy (2015); the Health Act, 2017, National Reproductive Health Policy.
[3] WORLD HEALTH ORGANIZATION (WHO) ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2015 ANNEX 19, 73 (2015) *available at* http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf [hereinafter WHO, TRENDS IN MATERNAL MORTALITY 1990-2013].
[4] *Id*.; The 2014 Kenya Demographic Health Survey (KDHS) reported a maternal mortality ratio (MMR) at 362 deaths per 100,000 live births. KENYA NATIONAL BUREAU OF STATISTICS, KENYA DEMOGRAPHIC AND HEALTH SURVEY 2014 (2010), *available at https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf* [hereinafter KDHS 2014].
[5] *See* WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2010.
[6] UPR of Kenya - Second Cycle Thematic list of recommendations, Recommendation 142.165 (2015) [Hereinafter, UPR Kenya Recommendations, 2015].
[7] UPR Kenya Recommendations, 2015, Recommendation 142.43.
[8] UPR Kenya Recommendations, 2015, Recommendation 142.166.
[9] Committee on Economic, Social and Cultural Rights, *concluding observations on the combined second to fifth periodic reports of Kenya*, Para 53, E/C.12/KEN/CO/2-5(6 April 2016) [*hereinafter* CESCR Concluding Observations Kenya, 2016*]*
[10] Committee on the Elimination of Discrimination against Women, *concluding observations on the eighth periodic report of Kenya*, CEDAW/C/KEN/CO/8, Para 54 (17 November 2017) [hereinafter CEDAW Committee concluding observations Kenya, 2017]
[11] CEDAW Committee concluding observations Kenya, 2017, Para 38.
[12] CEDAW Committee concluding observations Kenya, 2017, Para 39 (a).
[13] CEDAW Committee concluding observations Kenya, 2017, Para 39 (b).
[14] Section 6, Health Act, 2017.
[15] Namely: Nairobi, Kilifi, Kericho, Bungoma and Homa Bay Counties.
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