



Status of Women & Girls in Kenya

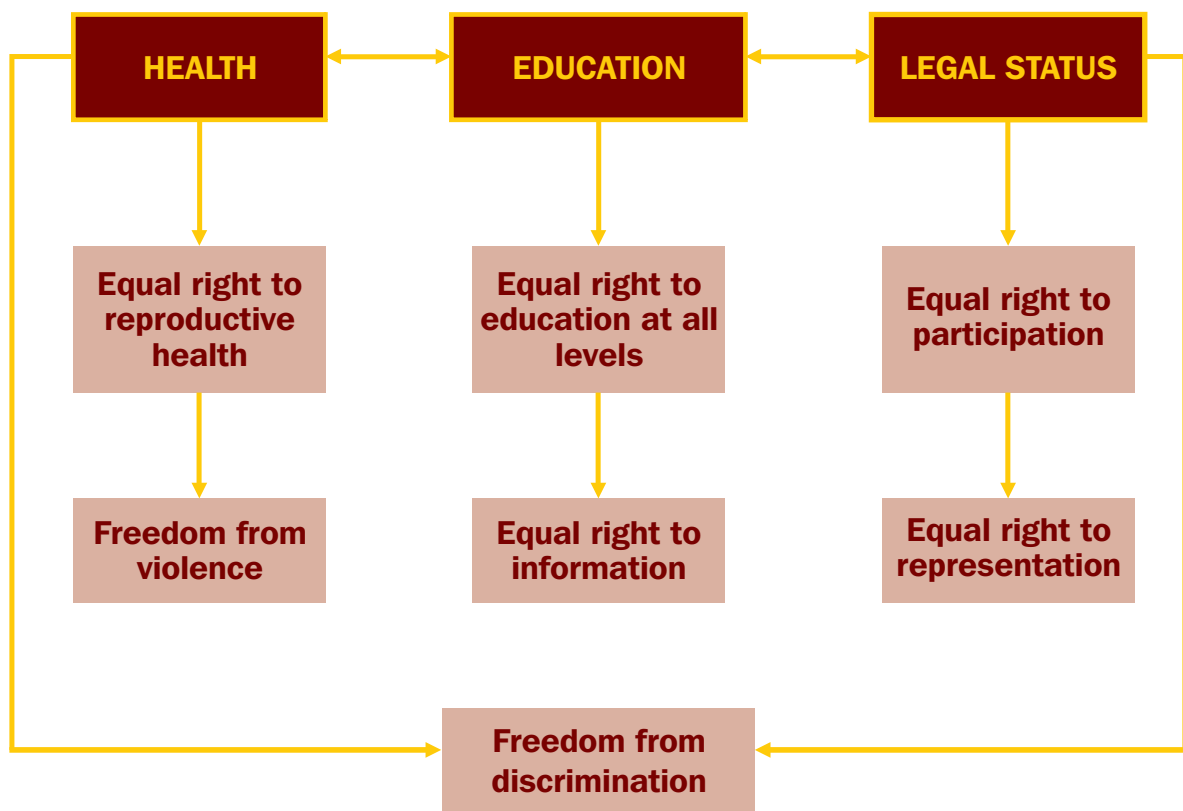


URGENT NEED TO UPHOLD HUMAN RIGHTS



Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

STATUS OF WOMEN & GIRLS IN KENYA: URGENT NEED TO UPHOLD HUMAN RIGHTS



**Towards the
promotion of equal freedom
and human rights of all
girls and women and Kenya**

TABLE OF CONTENTS

TABLE OF CONTENTS	ii
ACKNOWLEDGEMENTS	iii
GLOSSARY	iv
FOREWORD	v
EXECUTIVE SUMMARY	viii
HEALTH COMPONENT	1
1.0 Background	1
1.1 Life expectancy	1
1.2 Sexual & reproductive health	2
1.2.1 Maternal mortality	2
1.2.2 Abortion	7
1.2.3 Teenage pregnancy and motherhood	9
1.2.4 Contraceptive Use	9
1.3 Adolescent health	11
1.4 Infertility and Assisted Reproductive Technology (ART)	12
1.5 HIV/AIDS knowledge	13
1.6 HIV/AIDS prevalence	13
1.7 Gender based violence (GBV) & sexual violence (SV)	14
1.8 Female Genital Mutilation/Cutting (FGM/C)	16
1.9 Good Practice	18
1.10 Health Sector Reforms: Implication for women	18
1.11 Recommendations	20
EDUCATION COMPONENT	22
2.0 Introduction	22
2.1 International Conventions and Kenyan policies on education	23
2.2 Situation of Kenya's current education system	24
2.2.1 Pre-primary school enrolment	25
2.2.2 Primary school enrolment	25
2.2.3 Secondary school enrolment	26
2.2.4 Tertiary enrolment	26
2.2.5 Percentage of literacy	27
2.2.6 Education attainment	27
2.3 Good practice	28
2.4 Recommendations	29
RIGHT TO EQUITABLE REPRESENTATION OF WOMEN	32
3.0 Introduction	32
3.1 Health factors	32
3.1.1 Decision-making	34
3.1.2 Infertility	34
3.1.3 Sensitization of religious institutions	34

3.1.4	Hazardous cultural practices	34
3.1.5	Budget allocation by government for Reproductive Health (RH) services	34
3.1.6	Access to information on RH for both adolescents and women	35
3.1.7	More representation of women and gender in on going health sector reform	35
3.1.8	Parliamentary representation	35
3.2	Education factors	36
3.2.1	Representation in schools	36
3.2.2	Ministry of Education's quota system	36
3.2.3	Media, information and communication	37
3.2.4	Training of border police	37
3.2.5	Training and information on reproductive health in health facilities	37
3.2.6	Adult education	38
3.2.7	Police force/help desks	38
3.3	Legal factors	38
3.3.1	Discriminatory laws	38
3.3.2	Religious restrictions	38
3.3.3	Affirmative Action Bill	38
3.3.4	Sexual Offences Act	39
3.4	Recommendations	39
LEGAL COMPONENT		40
4.0	Introduction	40
4.1	Analysis of existing legislation vis-à-vis women and the girl-child	41
4.1.1	Constitution of Kenya	41
4.1.2	Gender Based Violence	41
4.1.3	The Penal Code Cap 63 laws of Kenya	42
4.1.4	The Sexual Offences Act and the Convention on the Rights of the Child	43
4.1.5	The Marriage Act & the African Christian Marriage and Divorce Act	45
4.1.6	Property Rights	46
4.1.7	Abortion	47
4.1.8	Female Genital Mutilation	48
4.1.9	Citizenship	49
4.2	Recommendations	49
BIBLIOGRAPHY		52

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GLOSSARY

Affirmative Action

Affirmative Action is a policy or a program providing protections for people of a minority group who are seen to have been historically discriminated against, with the aim of creating a more equal society. This consists of preferential access to education, employment, health care, or social welfare.

CBO

Community Based Organization.

CSO

Civil Society Organization

Human rights

They are the basic standards, which allow people to live in dignity without discrimination.

Gender based violence

Any act of violence perpetrated against any person by virtue of their vulnerability as a member of a certain gender or sexual orientation. Gender based violence results in, or is likely to result in physical, sexual or psychological harm or suffering to the victim. It includes threats of sexual violence, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Rape

Rape is a form of assault where one individual forces another to have sexual intercourse against that person's will. Consent may be absent due to threats arising from the use, or threat, of overwhelming force or violence, or because the subject is mentally incapacitated for example when intoxicated or too young to understand the nature of the sexual act or protest. Coercion/intimidation negates consent.

GER

Gross Enrolment Rate; the number of pupils enrolled in a given level of education regardless of age expressed as a percentage of the population in the theoretical age group for that level of education.

NER

Net Enrolment Rate; the number of pupils in the theoretical age group who are enrolled expressed as a percentage of the same population

KDHS

Kenya Demographic & Health Survey

Sector-wide Approach Programme (SWAp)

A process of engaging all stakeholders in sector planning to incorporate an integrated approach to the provision of services and mainstreaming and harmonizing different approaches with an aim of consolidating efforts and resources.

FORWARD

Many studies on girls and women vis-à-vis health and education have been carried out in Kenya. Conclusions have been made on the various issues afflicting and affecting them. Despite the necessity of accessing health and education services for this group of society, it is sad that in Kenya, only a small percentage can access these services easily with the majority having to contend with mediocre services that are few and in between.

For decades, women seeking reproductive health services in Kenya have been suffering serious human rights violations, including physical and verbal abuse and detention in health facilities for inability to pay hospital fees. Shortage of funding, medical staff and equipment plague the health care system, particularly the public health institutions, dramatically interfering with the ability of health care staff to provide adequate and quality care efficiently. These systemic problems have persisted, in part, because of a dismal lack of accountability within the health care system, which in turn stems from a lack of basic awareness about patients' rights and the absence of transparent and effective oversight mechanisms.¹

Looking at education, Kenya is faced with many gender and regional disparities. In North Eastern Province Gross Enrolment Rate for girls is 29% compared to 112% in Western Province.² In Nairobi's informal settlements only 22% of 15 to 17 year old girls were enrolled in school compared to 68% nationally and 73% in rural areas.³ In a country filled with cultural norms, girls in many communities are still seen as homemakers who do not deserve to go to school. Massive poverty has also crippled many families' efforts to educate their children despite introduction of free primary education. With the little resources that some families have, they prefer to send their boys to school since it is believed that they are future wealth sources to their parents than the girls, as they will go on to be breadwinners. With HIV/AIDS killing many parents, many girls are left with the responsibility of taking care of their siblings, which inevitably takes them away from the classrooms.⁴

Kenya's legal system incorporates many laws concerning women. However, many of these laws, including the Constitution are discriminatory and have resulted in many women in Kenya having their rights violated, leaving them with little or no place for recourse. There have been several attempts to amend the Constitution in order to revise or discard laws and provisions within the Constitution that discriminate/ allow for discrimination of women. However these have not been successful. Dominant areas of discrimination are concerned with laws on inheritance, sexual and gender based violence.

Being a patriarchal society, Kenya has laws such as the Succession Act Cap 160 that discriminate against women when it comes to inheritance of property. Many women have been left destitute following the death of their husbands and fathers or after a divorce. Many of them succumb to threats and hostility from their in-laws, and move away from their homes to live in abject poverty.

The dominance of patriarchy in the society has also led to acceptance of gender based and sexual violence as normal behaviour. Traditionally, women in some communities even expect to be beaten by their husbands as a sign of love! The Sexual Offences Act 2006 has introduced stiffer penalties for sexual offenders in Kenya, but implementation and enforcement of the Act are still not mainstreamed despite the gender-based violence and sexual violence statistics rising. Marital rape which is also rampant has however not yet been criminalized as a crime punishable by law.

Nationally, young women under 24 years make up one fifth of the population. And yet reliable statistics and details on girls and women status are scarce, contradictory or specific to one region and lacking in others. The purpose of this booklet is to assist in the support of programme designs in order for the government, NGOs, Development Partners and the United Nations to reinforce programs for women and girls in this country. This publication shall not only provide information on the status quo with regards to women and girls vis-à-vis health, education and legal status and human rights in Kenya also expose weak areas where additional work is needed to improve on the said status.

¹Centre for Reproductive Rights, FIDA (K), 2007. Failure to Deliver; Violations of Women's Human Rights in Kenyan Health Facilities

²Ministry of Education, Science and Technology, 2004

³African Population and Health Research Centre, 2003

⁴Joint UN Programme on HIV and AIDS in Kenya, Oct 2006. Facts & figures about girls and young women in Kenya.

EXECUTIVE SUMMARY

This booklet's focuses on laying emphasis on the current situation of girls and women vis-à-vis health, education and legal status and human rights in Kenya. Under each component, key areas of significance will be dwelt upon with the hope of assisting in the making of crucial conclusions and provoking implementable recommendations.

Under the health component, this booklet will highlight the following vital areas: life expectancy, maternal mortality, HIV/AIDS prevalence and knowledge, gender and sexual based violence, female genital mutilation, abortion, fertility, contraceptive prevalence and infant /child health and nutrition. In the end it is hoped that crucial decisions and conclusions can be made for girls and women in Kenya to have better access health care and services, and promotion of their sexual and reproductive rights.

The education component will look at primary and secondary school enrolment as well as enrolment at university level. Education attainment and illiteracy levels will also be examined. These areas portray the level of empowerment that girls and women are have been able to access, since higher education empowers women to better provide for themselves and their families, and to exercise their human rights.

Under the Legal status of girls and women, this booklet will look at the following areas as pertains to the laws of Kenya: gender based violence, sexual violence, female genital mutilation, abortion, property rights and citizenship. In order for equality and equity, women and girls require for laws relating to these issues to be able to protect and empower them instead of discriminating them.

In the end, it's hoped that every reader will have a clearer picture of the situation of girls and women in Kenya vis-à-vis their health, education and legal status. Hopefully, it will help us to create ways of amending and improving the situation in order for all women and girls in this country to access quality health, education and legal protection and exercise their rights equally, without any prejudice.

HEALTH COMPONENT

1.0 Background

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW, 1979) says that, “States shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Also States shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”⁵ Goal 5 of the Millennium Development Goals targets to reduce by three quarters the maternal mortality ratio between 1990 and 2015.

The health situation of the Kenyan population, to a large extent, is characterized by low life expectancy, high maternal and infant mortality and high morbidity from preventable diseases, including HIV/AIDS. Access to health care is characterized by strong regional and income disparities as well as by gender-specific and socio-cultural factors that hinder access for various vulnerable and marginalized groups. In many areas, the poor and those in arid and semi-arid areas cannot access health care or have to walk for miles to get to hospitals that have poor facilities and are understaffed.

Access to essential reproductive health services for women is still very limited, especially in rural areas. The unmet need for family planning is high and unsafe abortion is a major problem, predominantly for poor and unmarried women, leading to high maternal mortality, infections and infertility. Gender-based violence is widespread in Kenyan society and considered as an acceptable behaviour by majority of society.⁶

1.1 Life expectancy

The Life expectancy of women in Kenya has been falling steadily since the early 1990s and is now at 50 years, lower than that of men, which is at 51 years.⁷ This can be attributed largely to the HIV/AIDS epidemic that tends to infect and affect women more than men in Kenya, as is the case in many parts of the world. Low life expectancy is negatively affecting the economy because people's lives are cut short before they are able to adequately contribute as valuable human resource to enhancing the countries development. The training that is needed for new recruits within the work force increases operational costs not to mention the extra time incurred in building.

Orphans

About 10% of Kenya's 15 million children are orphans; those who have lost their parents to HIV/AIDS number about 650,000.⁸ The orphans left behind by parents who die prematurely (before the children are old enough to take care of themselves) are left vulnerable to abject poverty, not being able to afford even their most basic needs. Such children are also exposed to many kinds of abuse from the society, as well as from their surviving relatives, and live in a vicious circle of human rights violations.

A joint report by the WHO and UNICEF states that, “HIV/AIDS pushes children to the streets, as parents die and living relatives are unable or unwilling to provide care. Some of these street children are involved in sniffing glue or solvents, which increase their libido, hence the high risk of contracting sexually transmitted diseases, including HIV/AIDS. An estimated 3.5 million children are in the labour market, and school dropout cases are on the rise. Those in school perform poorly, owing to their ill health and the stigma associated with the pandemic.”

⁵CEDAW, 1979. Article 12

⁶GTZ-Kenya Development Cooperation, 2006. Report of the Advisory Mission.

⁷Joint United Nations Programme on HIV/AIDS, 2007

One of the many examples is Carol Kendi. She lives in Korogocho slums (a makeshift establishment in the outskirts of Nairobi). Her mother died two years ago when she was only ten. Her grandmother was aging. So she became the breadwinner of the family. At age 14, she was selling her body and in the process she conceived and had a baby. "I had to do this to care for my baby, my grandmother and my two younger siblings," she says.⁹

1.2 Sexual & reproductive health

1.2.1 Maternal mortality

Maternal mortality (pregnancy-related deaths) is the leading cause of premature death and disability among women of reproductive age in Kenya. There is no single cause of death and disability that affects men at this magnitude. Maternal mortality in Kenya is frighteningly high, at 410 per 100,000 live births per year. About 14,700 women of reproductive age die each year from pregnancy related complications while between 294,000 and 441,000 suffer from disabilities caused by complications during pregnancy and childbirth.¹⁰ Coupled with poverty, malnutrition, preventable diseases like Malaria and HIV/AIDS, maternal mortality is escalated by the poor quality of health facilities in many rural areas, lack of adequately trained personnel and the long distances and inaccessibility of health facilities.¹¹



Annually Kenya loses 6000 pregnant women from pregnancy and childbirth related complications.



This equals 600 X 10 seater matatus full of pregnant mothers



This equals 60 X 100 seater planes full of babies

⁸Ministry of Gender, Sports, Culture and Social Services, UNFP, 2005

⁹David Njagi, News from Africa 2004. No respite for AIDS orphans

¹⁰NCPD, CBS, ORC, 2003. Kenya Demographic and Health Survey

¹¹Ibid 10

Access to high quality health service is therefore critical to reduce maternal death and various health care interventions such as those mentioned below would highly contribute to the reduction in maternal mortality:

- Access to family planning
- Access to prenatal care
- Access to skilled delivery at birth
- Access to emergency obstetric care for complication
- Access to post natal care

Increasingly health professionals have recognized the protection and promotion of human rights as an essential condition for health. The problem of maternal mortality illustrates well the relationship between health and human rights. For example women's health requires social and economic rights such as equitable access to information and health services, adequate food & clean water, individual freedom to freely enter marriage, and access to birth control methods to influence number and spacing of children.

International Human Rights Framework

The ability of a woman to survive pregnancy and childbirth is an expression of her right to life. This right can be realized if women have access to high quality reproductive healthcare, are free from social cultural, economic and legal discrimination and have autonomy over decisions relating to their reproductive rights and sexuality. The Government has an obligation to provide conditions, which guarantee women's human rights under international law.

Even though the right to life is safeguarded in the Constitution many girls and women in Kenya are frequently violated at horrifying scales. Figure 1 shows that availability of emergency maternity services according to the 2003 KDHS was 27% nationally and ranged from 21% in Rift Valley province to 46% in Western Province. These are dismal percentages with the knowledge of the need for emergency services incase of childbirth related complications.

Figure 1: Availability of Emergency Maternity Services, KDHS, 2003

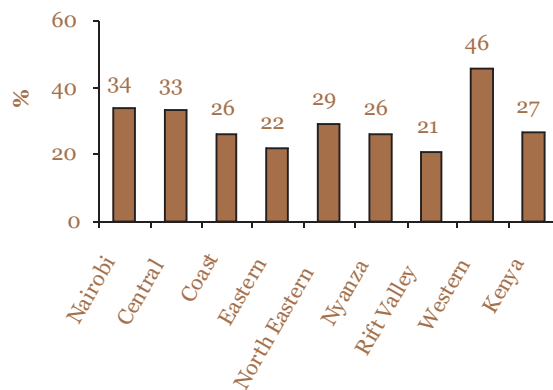


Figure 2: Percentage of women with an unmet need for family planning, KDHS, 2003

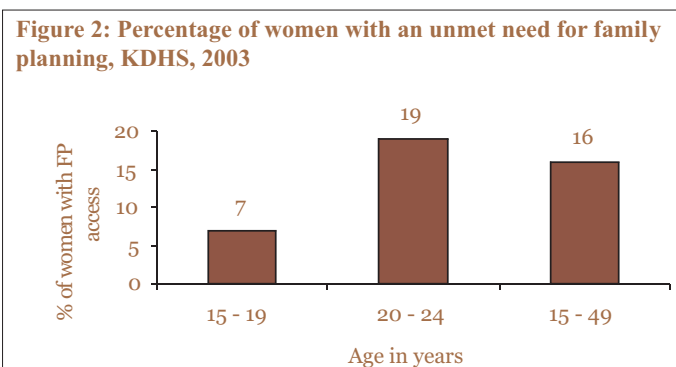


Figure 2 shows that the percentage of women with access to FP ranges from 7% for those aged between 15 and 19 years (who are most probably still in school) to 19% for those aged between 20 and 24 years. With lack of access to these FP services, girls and women are less able to space their births, or have the number of children desired. This increases their vulnerability to birth related complications and maternal death.

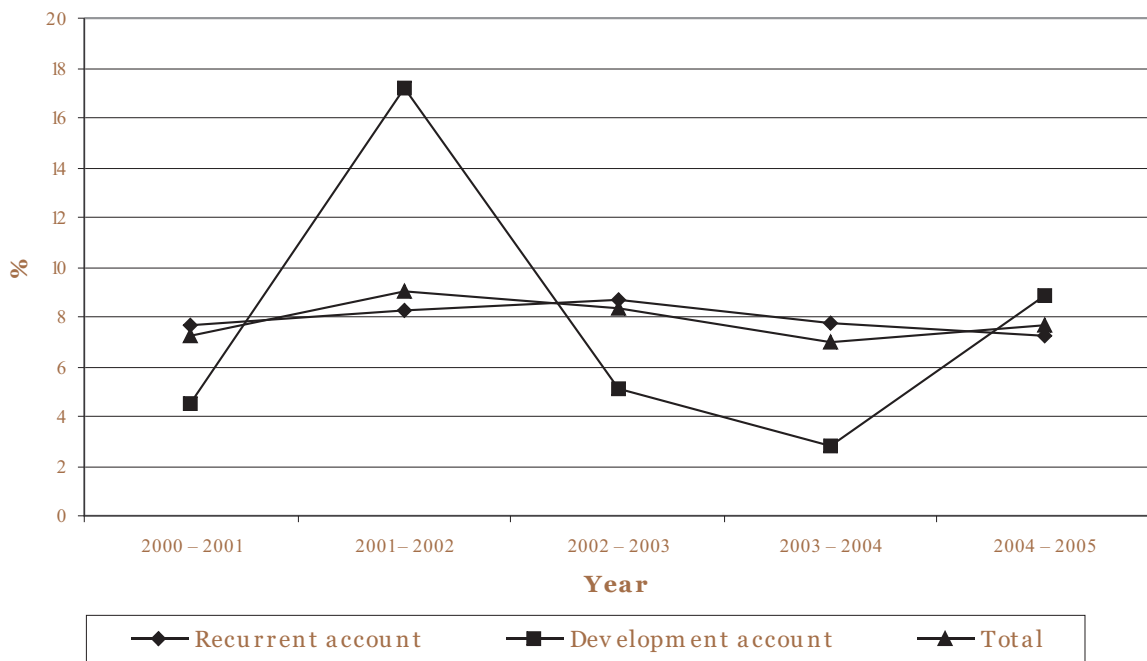
Kenya Ministry of Health expenditures, for the Recurrent and Development Accounts, in Ksh and US\$ (millions)

	2000 – 2001	2001 – 2002	2002 – 2003	2003 – 2004	2004 – 2005
Recurrent account	11,041	12,715	14,405	15,438	15,952
Development account	1,032	2,519	945	1,003	7,659
Total	12,072	15,234	15,351	16,441	23,611
Per capita Ksh	395.49	488.44	481.97	506.05	712.67
Per capita US\$	5.05	6.28	6.29	6.52	9.10

Source: Ministry of Health (Kenya)

The lack of adequate funding for public health facilities contributes to the emergence of a two-tiered health care system in Kenya, which discriminates against poor women and prevents or delays access to much-needed health care. For example, as per the 2004–2005 budget, the Ministry of Health expenditure was about 8% of the total government expenditure, a slight increase from the 2003–2004 budget in which it was 7%. The per capita public expenditure stood at Ksh. 395 (USD 5.05) in financial year 2000/01, Ksh. 488 (USD 5.61) in 2001/02, Ksh. 482 (USD 6.29) in 2002/03, Ksh. 506 (USD 6.25) in 2003/04 and Ksh. 713 (USD 9.10) in 2004/05. Despite the increase in per capita expenditure, it is below the World Health Organization (WHO) recommended USD 12 needed to provide a minimum package of health care services.

Ministry of health expenditure as a percentage of total government expenditure, Ministry of Health, 2005



Under CEDAW the government must refrain from acts of discrimination against women, work proactively to modify social and cultural conducts of men and women in order to eliminate prejudice, customs and practices. The magnitude of maternal death and disability is a reflection of a systematic inequality and discrimination suffered by women in Kenya throughout their life cycle.

The International Covenant on Economic, Social and Cultural Rights (1966) provides that, “States should ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.”¹² Also it says that, “States should recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹³

The Protocol to the African Charter on the Rights of Women in Africa (2003) covers a range of human rights issues. It calls for the reproductive right of women to medical abortion when pregnancy results from rape or incest or when the continuation of pregnancy endangers the health or life of the mother. It also calls for the legal prohibition of female genital mutilation (FGM). The rights of particularly vulnerable groups of women, including widows, elderly women, disabled women and women in distress, which includes poor women, women from marginalized population groups, and pregnant or nursing women in detention, are specifically recognized.

Poor women who are unable to afford basic health care services, and therefore they opt to deliver at home without medical supervision risk life threatening complications. Although the Ministry of Health has recently declared that delivery will be free at all public health facilities there are still many out of pocket expenses incurred in accessing these services, including transport costs and cost of medicine, that hinder access to health services for poor women. To remedy the lack of easy access to health facilities, mobile health clinics have been introduced in rural areas. Instead of the people visiting the health centre when they are sick, the mobile clinics have brought health services to where the people live. The clinics have therefore substantially increase accessibility of diagnostic, preventive and curative services to people who in the past had to walk long distances to seek medical attention.

Discrimination also exists in geographical disparities with regards to the distribution of health care facilities and the quality of health services. Many women in rural and marginalized communities have no health care facility within their vicinity, and have to travel unreasonably long distances to find a facility to deliver, or receive pre & post-natal care. Lack of communication infrastructure, lack of proper roads, and scarce means of transport to the health facilities, further aggravate this situation, with many women dying from birth-related complications, which are preventable if only they arrived in hospital on time.

It is therefore imperative and urgent for these essential services to be made accessible to all women equally; hence there should be adequate allocation of funds to reproductive health services, including maternal health care because they are crucial in enabling detection of birth complications and also facilitate access to emergency facilities and Personnel, should complications at birth occur. Again, access to information spelling out the importance of these health care facilities is imperative; it would amount to nothing to have them available and not have the women know of their availability and importance.

The government of Kenya manages slightly over half of all health facilities in the country while the rest, including the majority of maternity homes, are owned and run by non-governmental, private, and Faith Based Organizations. While government facilities cost less money, they tend to have long lines, suffer from congestion, are understaffed, have Over-worked staff, over-stretched facilities, lack supplies, and treat patients unequally. Women express a firm belief that money usually buys better treatment, and when they can afford it, they opt for private facilities.¹⁴

¹²Article 3, International Covenant on Economic, Social and Cultural Rights

¹³Article 12, International Covenant on Economic, Social and Cultural Rights

¹⁴Ibid 1

The difference between delivery in public and private facilities is often stark, with women contrasting the rude treatment from staff and dirty, overcrowded quarters at public facilities with the attentive care they received in a private facility. The trauma endured by women in a public health facility previously, determines the care they choose for the next birth experience, with many who cannot afford private facilities choosing to avoid health facilities all together. This further endangers the risk to their lives and those of their children if they do not seek assistance from a skilled birth attendant who can detect birth complications during their next delivery.¹⁵

Province	Private Hospital %	Public Hospital %	Home %
Nairobi	38	40	22
Central	50	17	32
Coast	24	8	67
Eastern	26	11	61
Nyanza	22	14	63
Rift valley	23	13	63
Western	17	12	71
North Eastern	7	0.3	92
TOTAL	26	14	59

Although antenatal care coverage is as high as 88% nationally, delivery in the presence of skilled attendants is only 42%. This implies that more than half of women in Kenya deliver under hazardous conditions, mostly at home. Disparities per region exist; for example, while 78% of women in Central Province deliver with the help of a skilled attendant over 92% of women in North-Eastern Province do not access this service.¹⁶

This is indicative of social and cultural influences and attitudes towards delivery. For example Muslim women predominantly deliver at home because it is taboo to be attended to by male birth attendants' who are majority of

health care workers. The Luhya community believes a baby should be delivered within the homestead, because this has a bearing on the child's identity and inheritance status. There are also cultural beliefs and rituals on adequate ways of disposing off the umbilical cord, deterring women who do not want doctors to dispose of it at the hospital.

Community awareness programmes especially targeting poor and rural communities should therefore be scaled up, and include education on pre and postnatal care. Training of skilled birth attendants also needs to be scaled up to deal with the special preference of certain communities to home deliveries.

1.2.2 Abortion

Abortion laws in Kenya are restrictive. Although the Constitution guarantees right to life, this right is qualified both in the Constitution and through subsidiary legislation. Section 63 of the Penal Code of Kenya allows for procurement of an abortion only in cases where the woman's physical or mental health is endangered BUT is not automatically guaranteed. The right of a woman to procure an abortion is recognized internationally and expressly articulated for example by The United Nations Human Rights Committee's General Comment 28, which advocates for the right of a woman to abort in case of a rape related pregnancy and also The Protocol to the African Charter on the Rights of Women in Africa which is the first legally binding human rights instrument to expressly articulate women's reproductive rights as human rights and to expressly guarantee a woman's right to control her fertility.

Article 14 (2c) of the Protocol provides that State parties shall ensure that women's right to health, including sexual and reproductive health is respected and promoted. This includes: protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life

- ❑ In Kenya 316,560 abortions are performed annually.
- ❑ 20,893 women hospitalized with abortion related complication in the public hospitals only.
- ❑ 48% of the abortion cases are in the adolescent/youth aged 14 to 24 yrs

of the mother or the foetus. Specifically, the protocol is the first human rights instrument to expressly articulate a woman's right to abortion in specified circumstances. Kenya has however not ratified this Protocol and has therefore not domesticated its provisions

Abortion is not legal in Kenya despite shocking statistics that indicate extremely high cases of high morbidity and mortality associated with unsafe abortions. According to a 2004 study, 300,000 terminations of pregnancy occur

with about 20,000 women and girls being admitted to hospital with abortion-related complications.¹⁷ And these figures exclude those who seek care from private institutions. Official statistics show that 30-50% of maternal deaths are as a result of unsafe abortions each year.¹⁸ Outside the urban centres, post-abortion care services are very rare.

Women determined to end unwanted pregnancies turn to unsafe abortion when access to safe services for pregnancy termination is legally or otherwise restricted. A horrendous revelation is that about 4 out of 10, (almost half) of women who die from unsafe abortion complications are adolescents.¹⁹ High rates of unsafe abortion among the youth in Kenya can be associated with lack of access to responsible sexual and reproductive health and contraceptive information and services.²⁰

1.2.3 Teenage pregnancy and motherhood

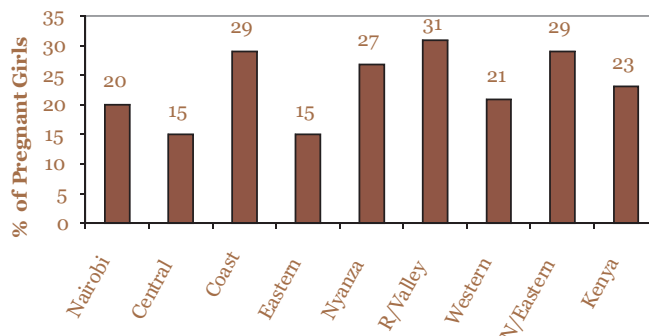
Sexual activity among adolescent Kenyans begins quite early , with many different partners before marriage. Sexual activity is usually unprotected leading to unwanted pregnancies, unsafe abortions, dropping out of school prematurely, contracting STIs and STD's including HIV/AIDS.²¹

Pregnancy and childbirth among adolescents

According to the 2003 Kenya Demographic Health Survey, teenage pregnancy is frequent and the study found that a quarter of young women aged 15 – 19 years were either pregnant with their first child or were already mothers. Figure 3 shows the rate of teen pregnancy as highest in North Eastern Province and Coast (29%) and Rift Valley (31%) and Nyanza (27%). Further statistics from the survey show that 19% of teenagers were mothers, 5% were pregnant with the first child and 23% of them had begun childbearing.

Contraceptive prevalence rate nationally (1997-2005) was 39% with merely 23% of all women using a modern method of contraception. Of all those married; only 32% use a modern method. For sexually active unmarried women, 44% of them use a modern method. Among those aged 15-24 who have had sex and are single, only 20% used a condom during their first sexual encounter. Among married girls aged 15-24, only 5% are using modern contraception.²²

Figure 3: Percentage of pregnant girls by province, KDHS 2003



¹⁵Ibid 1

¹⁶UNICEF, WHO, 2006

¹⁷Gebreselassie et al., 2004, The Magnitude of Abortion Complications in Kenya. British Journal of Obstetrics and Gynecology 111 (2004): 1-7

¹⁸Joyce Mulama, Break the Silence on Abortion, Aug 2006

¹⁹ipas, 2003

²⁰Fergusson A.D 1988, Kigundu J.G. 1986

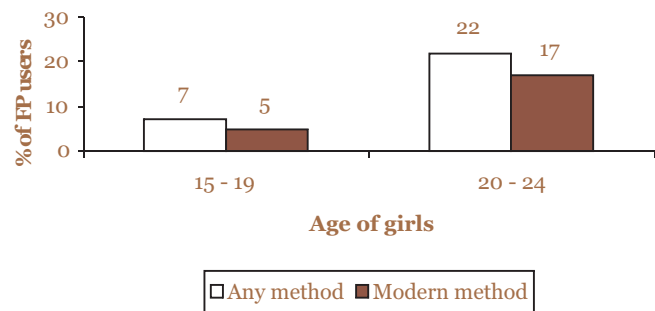
Although 96% of women aged 15-49 and 98% of men aged 15-54 know at least one method of modern contraception, the above outlined percentages of contraception use are rather low. This indicates that the family planning need in Kenya is not fully met. 24% of married women in Kenya who would like to space or limit their births are currently not using any method of contraception.²³

1.2.4 Contraceptive Use

Contraceptive methods are grouped into modern and traditional methods. Modern methods include: female sterilization, pill, IUD, injectables, implants, male condom and female condom. Traditional methods include: periodic abstinence (rhythm method), withdrawal and folk methods.

The Kenya Demographic Health Survey of 2003 indicates that at the time of the survey, about 38% of currently married women were using some method of contraception. The study revealed that modern methods of contraception (31%) are more commonly used as compared to the traditional ones (8%). Of the modern methods, injectables (13.8%) are the most widely used while periodic abstinence (6.3%) is the most popular traditional method.

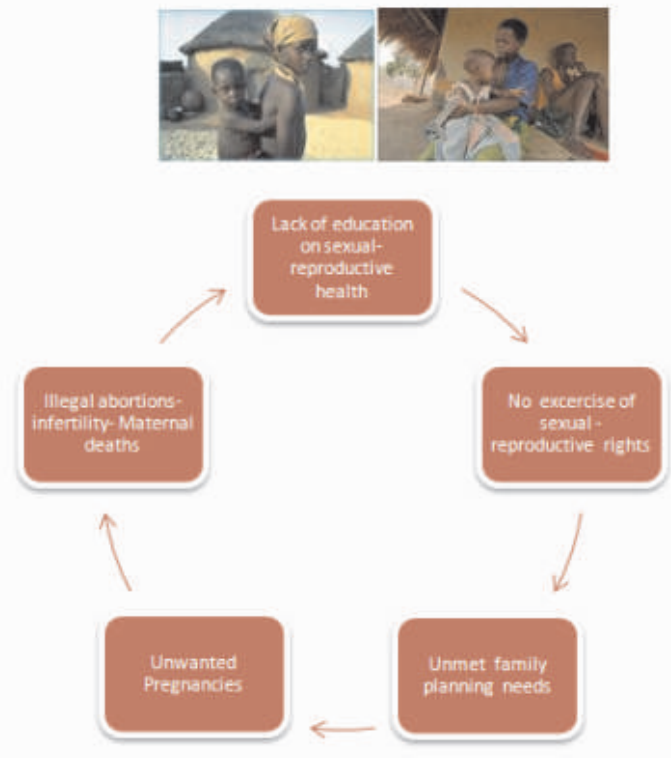
Figure 4: Percentage of Family planning users by age of girls, KDHS 2003



The results of the survey indicate that:

- Contraceptive use among married women has not changed since 1998, when 39% of married women were using a method.
- There are no major changes in the mix of methods used, apart from a slight decline in female sterilization and use of the pill and an increase in use of injectables and implants
- Since the early 1980s there had been a steady increase in family planning use among married women. The rate of increase slowed down between 1993 and 1998 and now appears to have stagnated at 39%.
- Contraceptive use by differentials reveals the following:

LINKAGES: EFFECTS OF NON-FULFILMENT OF WOMEN'S SEXUAL-REPRODUCTIVE RIGHTS



²¹Ministry of Health, 2005. National Guidelines for the Provision of Youth Friendly Services (YFS) in Kenya.

²²UNICEF, 2006

²³Ibid 10

- Contraceptive prevalence rate (CPR) peaks among women in the 35 to 39 years age group (49%) and is lowest among women aged 15-19 (15%).
- CPR is highest among urban women (47%) compared to 36% for those in rural areas.
- Married women in Central province continue to have the highest CPR (67%), followed by Nairobi (52%). North Eastern Province has the lowest CPR of less than 1%.

Modern contraceptive use increases dramatically with the level of a woman's education. Studies have established that more than half of married women with at least some secondary education use modern methods, of contraception compared to only 8% of women with no education.²⁴ Sadly, funds that had been set aside to boost the Family Planning sector in the 1990s were channeled to HIV/AIDS when the epidemic threatened to wipe out the Kenyan population, and no back-up funding was channeled to family planning.²⁵ For many Kenyan women therefore, accessing family planning services remains difficult, especially for those in rural areas.

1.3 Adolescent health

Adequate information is crucial for youth and teenagers who are in this crucial stage of physical and psychological development.. They require information on their health, their sexuality and sexual rights (including reproductive health rights) to enable them to adapt to the changes in their bodies and to make informed decisions ,such as how and when to responsibly engage in sexual activity if at all.

The illustration sets out the link between lack of education on sexual and reproductive health and consequential outcomes such as unwanted pregnancies, illegal abortions and maternal deaths. Without access to vital information on their sexual and reproductive health rights and without empowerment to exercise these rights, adolescents make uninformed decisions, or act on ignorance and or peer pressure leading them to situations that can endanger their health and even their life. These include unprotected sex, unwanted pregnancies, illegal abortions, exposure to STD's and HIV/AIDS.

Cultural barriers to adolescent health exist widely in Kenya. Child marriages and practices such as female circumcision are still practiced as the norm in various communities, without consideration to the effect on the girl child's health. Many girls forced into child marriages begin child bearing in their teens, which either independently or coupled with female circumcision adversely affect their health and increases chances of birth complications, infertility and death. Between 1987-2005, 25% of girls studied had undergone forced child marriages,²⁶ despite the enactment of the Children's Act 2001, which outlaws this practice. Instances of female genital mutilation are still occurring despite legislation outlawing the same.

There is a great need to educate adolescents on their sexuality, sexual and reproductive health rights as a key step to improving adolescent health. In addition to adolescents, the police force, social workers, community leaders and parents also need to be sensitized on issues relating to adolescent sexual and reproductive health rights so as to ensure that harmful practices whether cultural or otherwise are curbed as a measure to safeguard adolescent health. There is also a need to facilitate access to responsible information on sexuality, reproductive health rights and adolescent health whether through regular school curriculum or extra curricula structures such as youth clubs.

²⁴Ibid 10

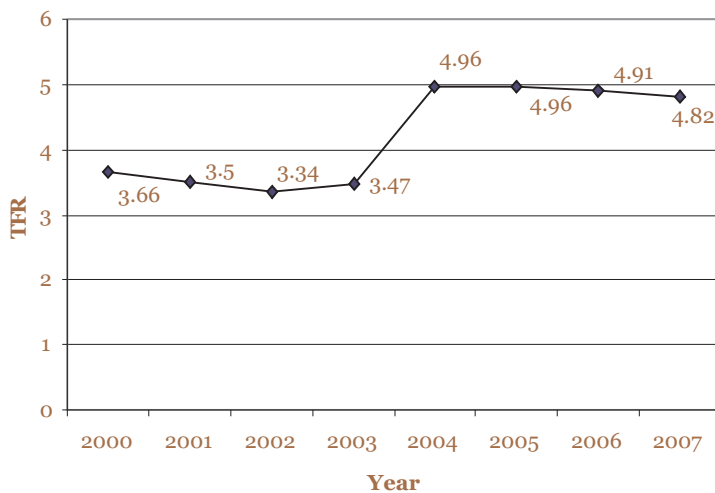
²⁵Peter W. Thumbi, 2005. Kenya country report on reproductive health and reproductive rights, emphasis on HIV/AIDS.

²⁶Ibid 22

1.4 Infertility and Assisted Reproductive Technology (ART)

Total fertility rate (TFR) in Kenya underwent a steady increase between the year 2000 and 2005 from 3.66 to 4.96. From 2006 it leveled off and stood at 4.82 on 1st of January 2007 according to figure 5.

Figure 5: Total fertility rate in Kenya, 2000 – 2007, CIA World Fact Book



In Kenya, as in many African countries, infertility is surrounded by misconception, myths and lack of adequate information about its causes, prevention or treatment. Local proponents, conversely, argue that infertility is a hardship for women, particularly in rural areas, where women are blamed for the condition and often divorced and ostracized as a result. There is also the myth that infertility is punishment from God or wrath of the ancestral spirits for sins committed, usually by the woman. The reality however is that infertility is a condition affecting both men and women, and it seriously

hinders the enjoyment of their reproductive rights, child bearing and founding families..

The main causes of infertility are STI's, postpartum & post-abortion infections, which are preventable and treatable. Tubal and male infertility, in particular, in many cases are correctable and fertility can be enhanced through Assisted Reproductive Technology (ART). Assisted reproduction refers to a number of advanced techniques that aid fertilization, including invitro-conception. ART services exist only in 4 clinics in Kenya and are not available in public health centres. This limits access to couples seeking treatment, and those who do access ART have to pay approximately US \$4300 in a country where the average per capita income is US \$360.

Affordability is just one of many ethical issues facing ART. In Kenya, as in other countries around the world, there is great moral, legal, ethical and social opposition to the technology, and stigma is borne by those who attempt to access ART. Access to ART however is a human right as acknowledged in the Cairo Conference of Population and Development (1994) which reiterates the reproductive right to decide freely and responsibly on the number and spacing of children and access to the information, education and means to enable couples to exercise these rights." The Vienna Declaration, Part I, Article 11 also emphasizes, "Everyone has the right to enjoy the benefits of scientific progress and its application, including biomedical and life sciences."

There have been media reports of children successfully conceived through ART methods in Kenya. However there previously existed no legal framework to support or regulate these procedures. It is against this backdrop that the Ministry of Health supported by German Development Cooperation through GTZ, commissioned a taskforce to create a regulatory framework for ART with the aim to develop legislation and regulations which will be necessary in order to protect rights of patients, guarantee safety, assure quality of ART treatment, and prohibit unethical practices or research in the area of human reproduction.

With a regulatory framework in place, and reduction of the high costs, Kenyan women and men, will be able to regulate their fertility and better exercise their reproductive rights, and reduce the social stigma and pressure borne by women due to infertility.

1.5 HIV/AIDS knowledge

Statistics show that 99% of Kenyans have heard of AIDS. Majority of women (81%) believe that one can prevent HIV by being faithful and 40% of them shockingly believe that there is little chance of them getting AIDS. 84% of women have never been tested for HIV. For teenagers, 14% of girls have had sex by age 15 and just about 12% used a condom at their first sexual encounter.

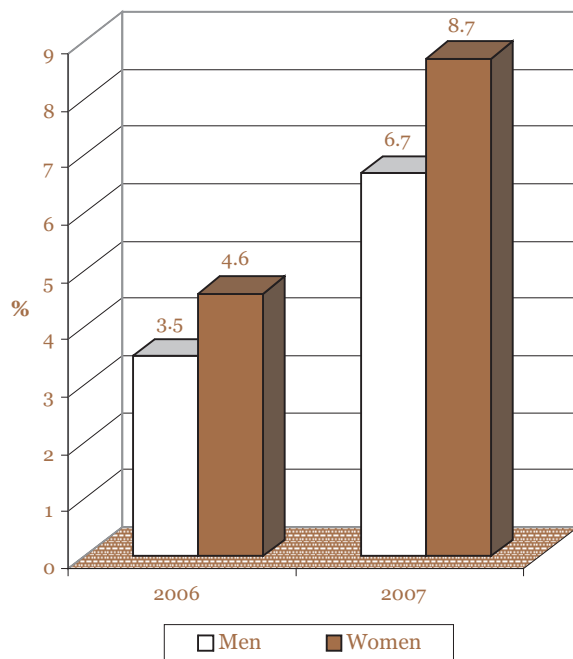
In 2003, 77% of women (and 86% of men) in the 15 to 24 years age group knew that abstaining from sex could prevent AIDS. Young women were better informed about condoms in 2003 than they were in 1998 where 59% of women (and 68% of men) in the 15-24 age group knew that using them could greatly reduce risk of HIV transmission, unlike in 1998 where only 33% of young women had this knowledge.²⁷

1.6 HIV/AIDS prevalence

Greater vulnerability of women to HIV infection has been attributed to biological, socio-cultural and economic factors, which range from harmful cultural and traditional practices that devalue their lives, low school enrolment, retention and completion rates, and relatively higher levels of poverty compared to men, which all combine to hinder their access to information and services.²⁸ According to the current statistics, Kenya's HIV prevalence was 5.1% in 2006, down from 5.9% in 2005 and 6.1% in 2004.²⁹ An estimated one million people are HIV-positive in the country, 934,000 of who are ages 15 to 49 and 102,000 of who are younger than age 14.

HIV prevalence among men was 3.5% in 2006, compared with 6.7% among women. The country recorded 55,000 new HIV cases in 2006.³⁰ A large share of new cases of HIV infection among women are due to gender based violence in the home, at school, in the workplace and in other social spheres.

Figure 6: Male and female HIV prevalence, KDHS 2003



The cause of the male to female disparity regarding infection is more complex than biology as mentioned previously. HIV/AIDS continues to take lives across Africa, especially women's lives, not simply because of sexual habits, but because of silent perpetrators that make them more vulnerable to the virus, such as limited access to education, domestic and gender based violence and early marriage.³¹

Half of all new HIV infections occur among youth aged 15-24. A 2002 study indicated that 4% of HIV infections in the 13-19 year age group were a consequence of rape. HIV prevalence among women aged 20-24 is over three times that of men in the same age group (9% and 2% respectively).³² In certain parts of the country, the ratio of girls to boys aged 15-19 infected with AIDS is almost 6:1!

²⁷Ibid 10

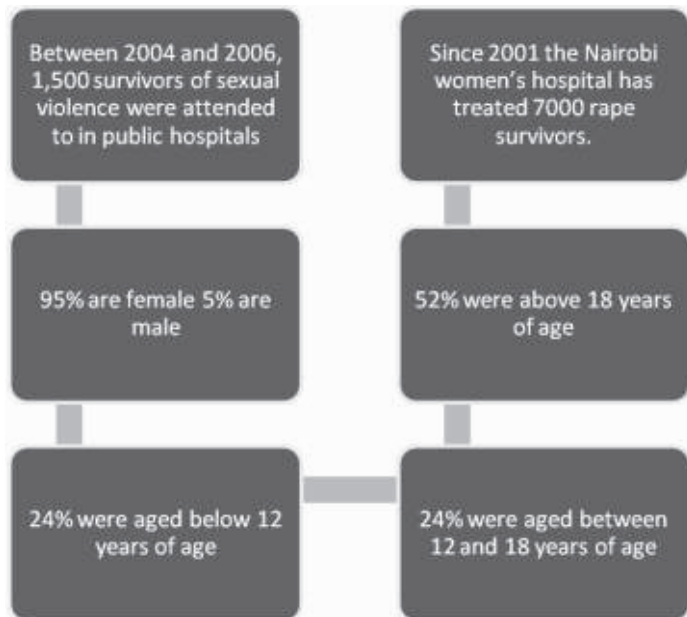
²⁸AIDS in Kenya, Trends, Interventions and Impact, 2005

²⁹(Ojanji, East African Standard, 8/14)

1.7 Gender based violence (GBV) & sexual violence (SV)

Gender based violence is widespread in Kenya and has for decades been perceived as normal behavior. Police statistics indicate 1440, 1365 and 1291 cases of rape were reported in 2004, 2005 and 2006 respectively. In the case of defilement, 1233, 1067 and 1445 cases were reported in the three years respectively. These figures are however not conclusive, as many women who are raped or suffer other forms of abuse are too intimidated by cultural attitudes, stigma and state inaction to report the violations or seek redress.

An aggregate of 10,117 sexual offences were reported in the last 3 years. According to these figures, there was a 12% increase in the total sexual crimes reported each subsequent year. Even with this noted increase in reporting of sexual crimes, The Kenya's Coalition on Violence against Women estimates that only 8% of women who are raped report the attack to health officials or police. They estimate the actual number of rapes per year is approximately 16,500.³³



The Nairobi Women's Hospital records the treatment of over 7000 rape survivors since 2001. The victims are treated with post-exposure prophylaxis (PEP) treatment, to prevent them from contracting HIV/AIDS. Those who do not receive PEP within 72 hours after exposure to the virus have a higher risk of later testing HIV positive and have to be referred for Anti-Retroviral Treatment, which is usually unaffordable and not readily available to many. Unfortunately PEP treatment is available in only 7 of the 73 government district hospitals in Kenya, and 1 of the 8 provincial hospitals.

According to the 2003 Demographic and Health Survey about half of Kenyan women have experienced physical mistreatment/abuse from the age of 15 years. 25% of them had experienced violence in the past 12 months. 26% of women have encountered marital violence that involved emotional brutality. 40% have encountered physical abuse and 16% have experienced sexual violence within their marriage.

In most communities in Kenya, adolescents are faced with many problems and violations of rights, including sexual abuse, as well as exposure to harmful cultural and traditional practices, such as early marriage and FGM.³⁴ In a 2001 nationwide survey of women aged 12 to 24, 25% said they lost their virginity through forced or coerced sexual intercourse. Sexual abuse of children is on the rise, with many cases being reported in Naivasha on the outskirts of Nairobi, where sexual violence has been inflicted on children as young as a few months old and women as old as 80 years. Sex tourism involving children is rampant in big cities and border towns.

2003 Demographic and Health Survey also shows that 1 in 10 adolescents aged 15-19 reports having experienced sexual violence. 1 in 5 girls are coerced/forced into their first sexual encounter. An

³⁰Alloys Orago, director of Kenya's National AIDS Control Council, on 6th Aug 07 at a press conference in Nairobi, Kenya

³¹Ibid 4

³²Ibid 10

³³<http://www.kenyapolice.go.ke/resources/COMPARATIVE%20FIGURES%202004,2005%20AND%202006.pdf>

³⁴Centre for the Study of Adolescence and Ministry of Planning and National Development, 2004

estimated 10,000 to 30,000 children have been caught up in the commercial sex trade. Many children resort to prostitution as a way to support themselves after fleeing violence in their homes.

Despite Kenya having signed or accented to various international and regional treaties such as The Convention on the Elimination of All forms of Discrimination (CEDAW) and the Optional protocol to the African Charter, there has been very little movement by the Kenyan government to domesticate provisions in these instruments which specifically call on State parties to enact legislation that promotes the rights of women and girls. The enactment of the Sexual Offences Act 2006 and the Children Act have attempted to domesticate some provisions of CEDAW and the International Convention on the Rights of the Child although a lot remains to be done in terms of fully domesticating provisions to strengthen legislation on the rights of women and the girl child.

1.8 Female Genital Mutilation/Cutting (FGM/C)

Circumcision of girls is a widely spread practice throughout Africa. There are different types of FGM/C:

- **Type 1:** The small protective skin that covers the clitoris is removed. Sometimes the clitoris or part of it is cut as well.
- **Type 2:** The clitoris together with all or part of the inner vaginal lips is removed.
- **Type 3:** All or part of the external genital organs is removed, and the vaginal opening is closed with stitches. This leaves only a small hole where urine and menstrual blood pass. This type is also called infibulation.
- **Type 4:** All other operations or manipulations on the external genital organs like introducing harmful substances into the vagina, cuts, stretching the vaginal lips or clitoris or pricking.

FGM/C is considered to be a thread in the social fabric that defines a woman's social standing and ultimately a community's identity. FGM/C is often practiced out of respect for and in conformity to society's culture and traditions. Others see it as a religious obligation, or a rite of passage into womanhood that ensures a girl's virginity and consequently her value and that of her family. Circumcision is also considered to increase likelihood of good marriage prospects. Also underpinning the practice are prescribed gender roles and understandings of men and women's sexuality.³⁵

Kenya Demographic Health Survey (2003) statistics show that on average 32% of women aged 15–49 years have undergone the 'cut' (a reduction from 38% in 1998) and 21% have had their eldest daughter circumcised.³⁶ FGM/C is more entrenched in the rural areas at 36% and is less manifested in the urban areas at 21%.

FGM/C related health complications include severe bleeding, anaemia, cervical infections, urethral damage, urinary tract infections, excessive growth of scar tissue & keloids, dermatoid cysts, chronic pelvic infections, post-birth complications, still-births, as well as difficult and often dangerous childbirth¹, leading to the death of the mother, child or both.

FGM has been recognized as a violation of women's sexual and reproductive rights as well as a great assault on their physical integrity. International treaties have recognized the hideous nature of female

circumcision including the Maputo Protocol on the rights of women in Africa,³⁷ which is a protocol to the Covenant on Peoples and Human Rights.³⁸ FGM/C has been outlawed in the Children's Act of Kenya but does not prescribe a specific punishment for persons found guilty of practicing or abetting its practice.

The Sexual Offences Act (2006) does not incorporate FGM as a crime against women, following the argument that the children's Act covers this crime and that FGM is not a "sexual offence". This legal vacuum created due to the non-protection of women not classified as children after attaining the age of 18 years, is a continuing barrier for women who are violated and forcefully mutilated especially when they marry into or come from communities carrying on the practice of FGM.

³⁵PATH, 2005, *Female Genital Mutilation in Africa: An analysis of current abandonment approaches*.

Ethnic group	FGM %
Somali	97
Abagusii	96
Maasai	94
Taita Taveta	62
Kalenjin	49
Embu	43
Meru	41
Kikuyu	33
Kamba	27
Other	21
Mijikenda/ Swahili	5

Many women who undergo this crude violation are left with permanent physical and mental scars. Added to that is the fear of rejection by their communities if they report the incidents or seek legal help for the violation of their human rights. Many of these cases therefore go unreported and the victims' road to recovery remains bleak. Recovery centres and shelters offering refuge for women escaping the threat of forced FGM are lacking in the country and there is need for scaling up and increasing shelters for those in danger of such abuse.

Although statistics 2003 Demographic and Health Survey results show a reduction of the practice, FGM/C continues to be practiced in many communities. Among the Somali, Maasai and Kisii, FGM/C prevalence is over 90%.³⁹ In communities where the prevalence is lower, the reduction has been largely due to increased education, female economic empowerment and introduction of the so-called 'alternative rites of passage', which replace the practice with rituals that retain cultural significance of a coming-of-age ceremony without physically harming the young women involved. In communities where FGM/C is linked to religion, scholars are being encouraged to be open in declaring that neither the Koran nor the Bible prescribes the practice. Men are also being sensitized to discourage the notion that

uncircumcised women cannot make potential spouses unlike in the past when they were considered unmarriageable and impure in these communities.

Criminalization of the circumcision of girls below 18 years in the Children's Act of 2001, however, has meant that the perpetrators have gone underground to avoid prosecution. This has made it even more difficult to get accurate statistics on the practice as well as made the work of rescuing potential victims harder.

1.9 Good Practice

GTZ through its Anti-FGM programme provides sensitization programmes through which inter-generational dialog is engaged with a view to creating alternative and humane rights of passage for girls and women in FGM practicing communities. In Trans-Nzoia for example GTZ carried out a successful program to reunite and reintegrate into the community girls that had escaped for fear of circumcision. Community counselors proved vital to this process to ensure the parents were sensitized to change their attitudes and protect their girls from FGM. Reintegration and rehabilitation of these victims is a big step towards their recovery and resumption of normal lives without stigma. Community creation awareness on the harmful effects of FGM and alternative rights must be expanded to assist victim recovery, and protect other potential victims.

Other anti-FGM activities undertaken by the program include:

- 1 Training of health workers to deal with complications arising from FGM during delivery and post-natal recovery period;
- 2 Sensitization of district administration officials (Chiefs, Sub-chiefs and the police) on the harmful effects of the practice and their role in enforcing the law;
- 3 Sensitizing women and men on the practice through organized community groups, barazas and the churches;
- 4 Training of teachers on how to address the issue in school especially through organized school health clubs and sensitizing the youth (in and out of school) on the harmful effects of the practice, how to fight for their rights and assist in the elimination of the practice;
- 5 Organizing quarterly Stakeholders meetings at the district level to strategize and ensure anti-FGM activities are included in the district health plans and implemented through coordinated efforts.

Ibid 10

Protocol to the African Charter on Human and Peoples Rights to the Rights of women in Africa Covenant adopted by the 2nd Ordinary Session of the Assembly of the Union Maputo, 11 July 2003

Covenant on Peoples and Human Rights: Adopted by the eighteenth Assembly of Heads of State and Government, June 1981 - Nairobi, Kenya

UNICEF, 2005

1.10 Health Sector Reforms: Implication for women

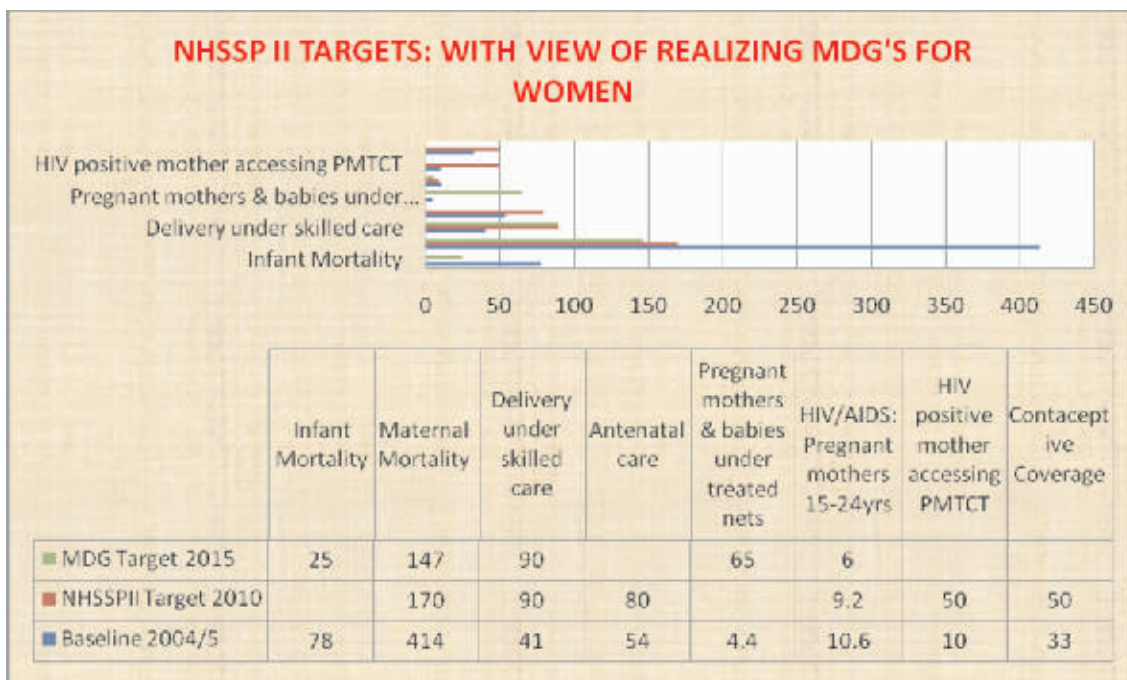
By 1994, the MOH health care delivery system was bedeviled with declining resources, inefficient utilization of existing resources, a rigid decision making structure, inequitable resource allocations, weak systems for monitoring and evaluation and weak management skills at district levels. At macro level, the health system was reeling under the heavy pressure from increasing burden of disease fueled by HIV/AIDS, infections increasing poverty levels and rapid population growths.⁴⁰ These all had a negative effect mainly on women who are frequent health care users especially during pregnancy and delivery.

NHSSP II POLICY OBJECTIVES

- ❑ Increase equitable access to health services
- ❑ Improve quality and responsiveness of services and sector
- ❑ Improve efficiency and effectiveness of service delivery
- ❑ Improve the financing of the health sector
- ❑ Enhance the regulatory capacity of MOH
- ❑ Foster partnerships in improving health and delivering services

However the Ministry of Health together with development partners developed a National Health Sector Strategic Plan (NHSSP I & II) as part of the health sector reforms, with a view of restructuring the health sector service delivery. It embodied wider issues of equity, social justice, and democracy, which have previously been ignored in the process of

health policy development. It also espoused such principles like community and private sector participation, and decentralization.



The NHSSP II was drafted in alignment with the Millennium Development Goals (MDG'S), and other international standard for the reversal of the downward trend of health indicators. Its projected targets and outputs have a great significance for women. It targets accessibility of health services to all Kenyans, and proposes to implement the Kenya Essential Package for Health (KEPH). The KEPH focuses on the health needs of individuals within their 6 life cycles, which encompasses a large coverage for girls in their early child development, adolescence and their adult reproductive health.

⁴⁰<http://www.health.go.ke/hpdcon.htm>

In addition, the MOH is planning to introduce in the coming years a National Social Health Insurance Fund (NSHIF). This is a social health insurance scheme to which everyone would contribute without exemption. For those too poor to pay, the government would pay for them. In its tenth year of phased implementation, the scheme would be targeted to give comprehensive health care to 80% of the population. The sources of funding would include payroll harmonization, general taxation, informed sector contributions, donations and grants.⁴¹

If properly implemented, this will greatly benefit poor women and those from marginalized groups, who have been historically exempted for lack of resources to contribute to health insurance. It will significantly contribute to fulfillment of their right to access affordable health care, without increasing their financial burdens and poverty, caused by high health care costs. Further, it will increase the access to health care services by pregnant women who were previously deterred from accessing health facilities due to affordability. Consequently there will be more deliveries in health facilities and better uptake of preventative and curative care, which have a impact on the reduction of maternal and infant mortality.

1.11 Recommendations

- 1 There is a critical need to have more girls and women actively participating in decision-making processes. Women must be at the core of decision-making on matters pertaining to reproductive health since they have the best understanding of the services that they require. They should be empowered by giving them more say in the programs and projects to be initiated for them in order to be able to access quality health care easily and equally including prenatal and antenatal care, family planning services, post rape services and post abortion care.
- 2 The draft Reproductive Health Bill 2007 that recognizes the right of all women to access comprehensive reproductive health care equally requires aggressive lobbying for its enactment.
- 3 Access to proper information on health care facilities and services should be readily available to all. The government should ensure that this is a priority in its health care funding. Policies should be formulated especially those that will be useful in improving girls and women access to reproductive health services.
- 4 Laws pertaining to reproductive health rights such as those that outlaw abortion should be reviewed and brought in line with international and regional instruments which Kenya has ratified or accented to and which recognize the right of a woman to determine for example the number and spacing of children she wishes to have.
- 5 Stiffer penalties should be introduced for perpetrators of sexual abuse. Marital rape should be recognized as a crime punishable . Resistance to these policies and decisions should however be anticipated from among other avenues including the church and communities that are embedded in tradition. For instance, some churches preach against the use of family planning services by unwed people, while many men in some communities practicing FGM refuse to marry uncircumcised women hence making eradication of FGM more difficult. Community sensitization and dialog should be scaled up and other solutions on how to overcome these challenges should amicably be sought so that harmony in the society is not annihilated.
- 6 Girls should have a right to choose whom to marry and when to get married as well as the right to say NO to FGM. Alternative rites, which are less dangerous, invasive and traumatizing, should be sought as a passage to adulthood for these girls.
- 7 Information on Post Exposure Prophylaxis needs to be more widely disseminated at both the national and community levels, to ensure that rape victims receive the highest chances of preventing the infection, as well as intensive training done to health officials and district and community levels to enable them to administer PEP's more effectively.

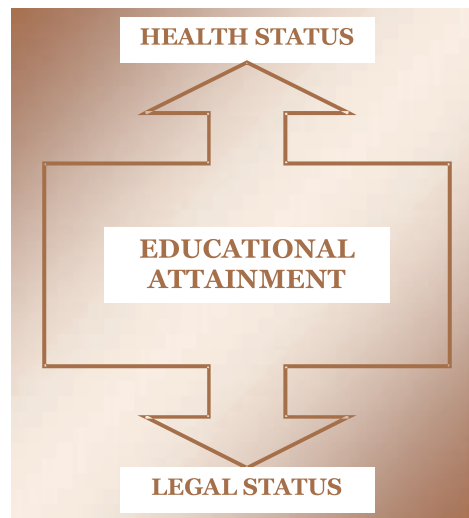
⁴¹<http://www.health.go.ke/hpdcon.htm>

EDUCATION COMPONENT

2.0 Introduction

Education is an important pillar that determines one's health and legal status. Without education, people are unaware of their rights and they have inadequate knowledge of basic health care skills. Literacy enables them, for example to read and understand prescriptions/labels, learn how to boil and store drinking water, prepare dehydration remedies, seek antenatal and postnatal care, treat mosquito nets, have their children sleep under the nets always, among other issues.

Education opens doors for rationalized thinking and reasoning. It provides opportunities for girls and women to learn and understand their rights, and to be able to recognize laws and social attitudes that are prejudicial to the enjoyment of their rights. This leads to empowerment to lobby for deletion/amendment or improvement of the said laws and social systems. Education is a useful tool in setting girls & women free from historical discrimination and disadvantage, enabling them also to teach their proceeding generations about the benefits of education. In a patriarchal society like Kenya, women will have to speak up in order to change the stereotypical notion that their place is only in the home as wives and mothers and that they are just there to be seen and not be heard.



Educating women benefits the whole of society. It has significant impact on poverty and development. It is also the most influential factor in improving child health and reducing infant mortality.⁴² Getting and keeping young people in school, especially girls, dramatically lowers their vulnerability to HIV. This is because each additional year of education leads to women having greater independence, they are better equipped to make decisions pertaining to their sexual lives and provides them with higher income-earning potential. In a country where many girls and women live in abject poverty and casually exchange sex for food and other necessities, it is crucial to keep

“We know from study after study that there is no tool for development more effective than the education of girls and women.”

Excerpt from speech by Kofi Annan

them in school.

The fact is that education leads to empowerment. For them to participate adequately and effectively in national development affairs, Kenyan women need to access quality education, and attain higher levels of learning. The government is obliged to provide such education if only to demonstrate its commitment to gender equity and equality for its entire population without prejudice.⁴³ The link between education and reproductive health is two-directional:

- Education of girls is closely related to improvements in family health and better management of fertility through family planning methods.
- Girls born into smaller families are more likely to be sent to school and to complete more years of schooling.

2.1 International Conventions and Kenyan policies on education

Goal 3 of the Millennium Development Goals is the achievement of universal primary education and for girls and boys to have equal access to all levels of education.⁴⁴ The 1948 Universal Declaration of Human Rights asserted that everyone has a right to education, education shall be free, at least in the elementary and fundamental stages and elementary education shall be compulsory.⁴⁵

Education is a fundamental right for all people, women and men, of all ages

⁴²Women's Empowerment & Reproductive Health. <http://www.unfpa.org/intercenter/cycle/education.htm>

⁴³Fatuma Chege, Daniel Sifuna, 2006, *Girl's and Women's Education in Kenya*

⁴⁴United Nations Millennium Declaration, 8th September, 2000

⁴⁵Universal Declaration of Human Rights, 1948, Article 26

The International Covenant on Economic Social and Cultural Rights (1976) recognizes the right of everyone to education. Article 10 of the Convention on the Elimination of All Forms of Discrimination Against Women (1979) says that States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education. Article 28 of the Convention on the Rights of the Child (1989) points out that each child has a right to education and proper measures should be taken to encourage regular attendance at schools and reduce drop-out rates.

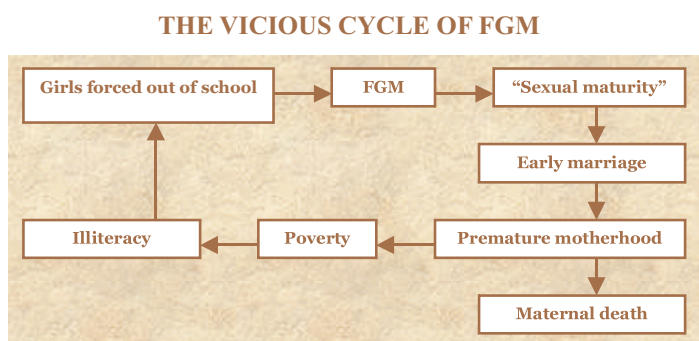
The World Declaration on Education for All and the Framework for Action⁴⁶ recognizes the necessity to give to present and coming generations an expanded vision of and a renewed commitment to basic education. The Declaration reaffirms that education is a fundamental right for all people, women and men, of all ages. Primary education must be universal, basic learning needs of all children must be satisfied. The culture and needs and opportunities of the community should be taken into account. The Declaration firmly asserts the objective of universal basic education.

Kenya is a signatory to the Jomtien Conference of 1990, Dakar Framework action of 2000, and Millennium Development Goals Conference of 2000. In an effort to achieve Education for All, it set out policies in the Sessional Paper No. 1 of 2005 an Educational Policy and Framework. This also led to the Kenya Educational Sector Support Programme 2005-2010 (KESSP), which has seen a lot of improvement in the provision of education to the girl-child and women. In its effort, it puts into consideration Affirmative Action in the awarding of bursaries to girls, improving sanitation in schools.⁴⁷

2.2 Situation of Kenya's current education system

Equality and equity in education in Kenya has not yet been achieved. Disparities exist regionally, in urban and rural areas and among various communities, due on social, cultural and economic factors. For decades, women in Kenya have been sidelined with their role being domesticated, being seen as belonging in the home and thus not receiving formal education which was reserved for boys who are expected to later use the acquired skills as family bread winners.

This has led to girls being less likely to attend and complete school. While boys attend school, girls stay at home to be groomed for marriage and matrimonial responsibility. Even where education opportunities are afforded to girls, equality is not achieved automatically, because girls are many times overburdened with domestic chores, impeding upon their ability to fully concentrate or participate in their studies. Many times, pregnancy ensures that they drop out of school permanently, or miss out on attendance to raise the child.⁴⁸



Women with higher levels of education tend to marry later and have fewer children. This notion is confirmed by the fact that early marriage in Kenya is higher in rural areas and those areas reporting lower levels of education.⁴⁹ Increasing girls' access to education is a key strategy to help end harmful practices such as female genital mutilation, because educated women are less likely to allow their daughters to undergo the cut.⁵⁰ The more girls are educated the

more they are able to make their own choices. Traditionally, FGM also signals the change of girls to 'mature women' who are eligible for marriage and forces girls away from school to become wives at a very tender age with marital and reproductive responsibilities.

⁴⁶World Conference on Education for All, 5th-9th March, 1990, Jomtien, Thailand

⁴⁷Kenya Education Sector Support Programme (2005-2010): Delivering Quality Education and Training to all Kenyans, July, 2005

⁴⁸Ibid 4

⁴⁹Ibid 10

⁵⁰Malini Morzaria, Zeinab Ahmed, UNICEF, 2006

Reduction of FGM lessens these incidences and ensures that more girls remain in school and achieve higher levels of education. "Female circumcision prepares girls for responsible married life", is one of the arguments for the practice of female circumcision. It's argued that girls who are not circumcised are immoral and make rude wives and daughters-in-law. In some communities it impressed upon the girls right from a tender age that no man will marry an uncircumcised girl, contributing to the girls consent to undergo this harmful ritual.

Although the Government has declared Primary Education free in Kenya, it is not really free to disabled and orphaned children. The Government provides each student with Kshs. 1000/= US\$ 13 per annum which is not enough for orphans to buy books, school uniforms or to provide for their special needs, such as wheelchairs, crutches, walking aides, and hearing aides among others. Considering that parents and guardians many times discriminate against disabled children, some even hide them; most disabled children do not access school and the few that do rarely complete their studies because they are unable to pay school fees.

Disabled students and orphans who somehow manage to overcome the Primary School hurdles, are rarely able to afford Secondary school fees ranging from Kshs. 25,000 to 50,000 (US\$ 328 to 658) plus annual expenses of additional Kshs. 50,000/= per child.⁵¹ Another bone of contention is that the current Kenyan Constitution guarantees civil and political rights but does not make provision for implementation of social, economic and cultural rights.

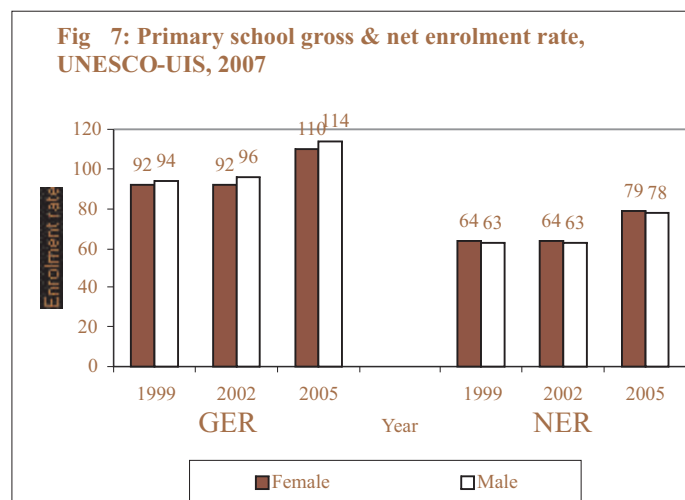
2.2.1 Pre-primary school enrolment

Pre-primary gross enrolment rate (GER) in Kenya is more or less equal for boys and girls and has been from 44% in 1999 to 52% in 2006.⁵² This is highly commendable.

2.2.2 Primary school enrolment

One positive observation from figure 7 is that primary school enrolment has increased between 1999 and 2005. GER of boys is slightly higher than that of girls for all years while net enrolment rate (NER) is higher for girls than boys. This is another commendable development. Introduction of free primary education by the current government has led to an increase of primary school enrolment and attendance. According to the Ministry of Education, Science and Technology Education Statistics Section (2003), total completion rate of primary school is 57% with 58% of girls completing their education compared to 61% of boys.

Though rates of primary school enrolment are increasing, an estimated 1.7 million children still do not attend school largely due to poverty, child labor and absenteeism by children struggling to maintain orphan headed households. 9 out of 10 children from poor households still fail to complete their basic education.⁵³ Teenage mothers of Kenya (TEMAK) reports that 8,000 to 10,000 girls drop out of school each year due to pregnancy. A staggering 90% of these teenage mothers are involved in prostitution.⁵⁴ This could be attributed to the fact that less than 40% of Kenyan parents give their children information about sex and sexuality.⁵⁵



⁵¹Kenya Programmes of Disabled Persons, 2003

⁵²Ministry of Education, 2007

⁵³Ibid 22

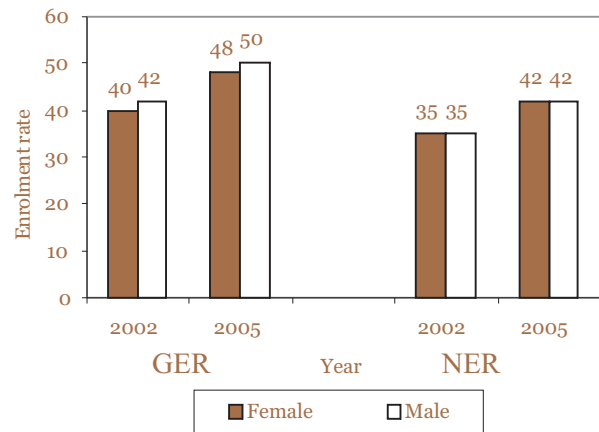
⁵⁴Mitchell et al, 2004

⁵⁵Muga et al, 2004

2.2.3 Secondary school enrolment

Gross enrolment rate of males according to figure 8 is slightly higher than that of females in 2002 and 2005 at 42% and 50% compared to that of girls at 40% and 42%. On the other hand in both 2002 and 2005, net enrolment rate of males and females appears to have been equal. This is very commendable. These rates are however a stark contrast to those of primary school enrolment. It shows that a lot of girls drop out of school after their primary education. Statistics show that girls who become pregnant while still in school are often expelled, despite the new policy that allows girls to return to school after delivery.⁵⁶ Therefore up to 13,000 girls drop out of secondary school annually due to pregnancy.⁵⁷

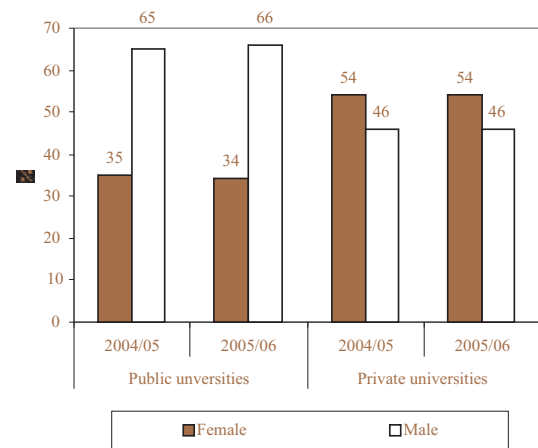
Fig 8: Secondary school gross & net enrolment rate, UNESCO-UIS, 2007



2.2.4 Tertiary enrolment

Of the students in university, figure 9 shows that the percentage of girls in public universities is lower than that of men at 35% and 34% in 2004/05 and 2005/06 respectively compared to that of men at 65% and 66%. In private universities, the opposite is true. In 2004/05 and 2005/06 periods, 54% of the students in these institutions were female compared to males who were 26% and 46% of the students here over the same period. This could be attributed to the fact that these institutions offer art-based courses that female students prefer and are more inclined to choose traditionally.

Fig 9: Tertiary enrolment rate, Ministry of Education, 2007



Despite the rapid expansion of higher education over the past two decades, challenges to access and equity remain. These include: inadequate capacity to cater for the growing demand for more places in the universities; a mismatch between skills acquired by university graduates to the demands by the industry; an imbalance between the number of students studying science based courses to those studying arts based courses; rigid admission criteria that excludes the possibilities for credit transfers amongst universities and for graduates from other post-secondary institutions; and gender and regional disparities in terms of admissions and in subjects and courses undertaken.⁵⁸

2.2.5 Percentage of literacy

The youth aged between 15 and 24 years have total literacy of 80% with that of females being 81% and that of males being 80% according to figure 3.2.5. Total adult literacy rate is 74% with adult female literacy rate being 70% and that of males being 78. While literacy levels of the youth are remarkably high, these diminish in adulthood more so for women from 81% to 70%. This indicates that many

⁵⁶FPAK 2003, FAWE News July-Sept 2000

⁵⁷IPAS, FPAK, 2003

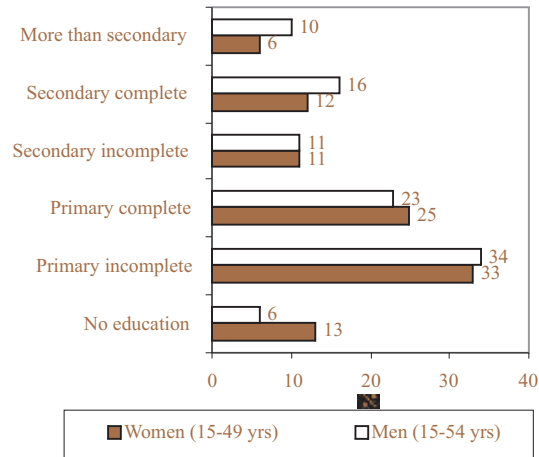
⁵⁸Ministry of Education, Science and Technology, 2004. Development of Education in Kenya

women above the age of 24 are illiterate. Illiteracy in adulthood should not condemn women to eternal poverty and hopelessness. Empowering them requires adult education, which should also incorporate entrepreneurship and business skills and other informal skills, they require in order to earn a livelihood and become economically independent.

2.2.6 Education attainment

The 2003 DHS indicates that many Kenyans have attained some level of education according to figure 2.2.6. It is an improvement to note that 25% of girls have complete primary education compared to 23% of boys and that levels of incomplete secondary education tally for both of them. However, it is sad that more than double the percentage of girls compared to boys have no education at all. Overall, about 40% of men have at least some secondary education compared to 29% of women.

Fig 2.2.6: Percentage of women & men education attainment, KDHS, 2003



2.3 Good practice

On HIV/AIDS and Education, the government of Kenya recognizes that with basic education women can engage in economic activities, thus contributing to great national productivity, reducing fertility rates by bringing up healthy, educated children and families, reduce infant and maternal mortality as well as to be able to protect themselves and their family against HIV & AIDS. With this in mind, the government has integrated HIV/AIDS education in the school curriculum in an effort to protect vulnerable orphan and children by equipping them with life skills.

Through the KESSP the Kenyan government has been able to offer grants to informal learning institutions in slum areas, to educate the many children of school going age there, who would otherwise have no education opportunities. Also it has been able to sponsor children in the Arid and Semi-Arid Land (ASAL) areas, who have not been going to school due to the long distances to schools in those areas. They have also been able to improve the girl-child enrolment by building boarding schools in the ASAL areas, which offer a better learning environment without the hustle of household chores and insecurity. After recognizing that enough classrooms and sanitary provisions for girls (including sanitary towels and incineration facilities) are lacking in many schools, the government has made an effort to provide these essential services in order to make learning for these children as comfortable as possible.

For the disabled in society, those who are already enrolled but for a variety of reasons cannot achieve education in mainstream schools, the government has started special schools, day/boarding, special units, integrated programmes, small homes and vocational centers. For those who are not enrolled in schools but who could participate if more schools were available or were responsive to diversity, the government has been using social workers, assessment teachers, churches and leaders to advocate for Education for All. For people with more severe impairments who have a need for some form of additional support, home-based programmes have been organized. A few parents have been trained on how to make adaptive aids and social workers visit parents at their homes while physiotherapists visit and train parents.⁵⁹

At secondary education, bursaries, which are aimed at enhancing retention of the bright and needy students and especially girls, are disbursed by Bursary Constituency Committees for better targeting. The school management committees and boards of governors have been given more authority to make decisions that will contribute to the provision of quality education.

⁵⁹Dinah J. Tangui, 2000. Issues about the Disabled and Education in Kenya. International Special Education Congress, University of Manchester

2.4 Recommendations

- In their quest to assist the disabled in society the government's efforts are hindered by a lack of school fees, an inadequate number of trained teachers, inadequate facilities and regular absenteeism due to long distances to schools. Other parents with disabled children use them to do odd jobs in the homes; having concluded that disability is inability. Also most parents hide their children for fear of stigma, and poor parents cannot afford physiotherapists for them. Many do not attend any training because some parents are over-protective their disabled children thus hindering their attendance to special schools.⁶⁰
- To remedy this, the government should train more teachers to deal with disabled children and build more schools for them. Disabled children should be afforded user friendly facilities including spacious and easily accessible toilets, as well as ramps for those on wheel chairs, to enable them to attend normal schools. This will integrate them into the society and avert stigma. Schools can learn to improvise facilities at hand in addition to looking for sponsors to finance the building of the necessary facilities required by the disabled children.
- Other countries could also be emulated, e.g. twinning method in Zambia and Trebuie in Romania. Twinning is an idea developed out of the idea that children are natural communicators and mentors. Children are paired so that they can work together and support each other within their schools and communities for inclusion. Twinning takes place between disabled and non-disabled children.
- They should have provisions to guide and counsel parents and the community and take parents to visit existing institutions and organize exhibitions for work done by disabled children. There should also be regular visits to parents, encouraging them to form an association to represent the needs of their children.
- About 5% disabled female pupils/students are expelled from school because of pregnancy. Assimilation capacity among some of the disabled is lower due to mental disability, thus they have little understanding or information about HIV/AIDS and safe sex. Regarding the different levels of assimilation among the blind, the deaf and mentally retarded pupils, there is a great variation and means of communicating with them e.g. for information message transmitted on the television. In order to adequately and efficiently inform disabled pupils/students/persons about the dangers of HIV/AIDS & STDs and pregnancy in adolescence. Special education skills must be applied.⁶¹
- With free primary education introduction, pupils have overwhelmed teachers and facilities thereby reducing the quality of education that pupils are getting. Proper funding, planning, implementation and monitoring needs to be integrated into the programme in order for free education to be viable. More teachers need to be trained and incorporated into the system. Those from the private sector can also be integrated to deal with the deficit through offering them incentives (e.g. through payment per hours taught). Regular inspections should be carried out to ensure that pupils are getting quality services from their educational institutions. •School feeding programmes should be increased to encourage children from the arid areas to attend school. The role of development agencies should become clear in the implementation of free education with proper funding sought when required to ensure that it goes on smoothly.
- For girls and women who drop out of school for one reason or the other, this should not spell the end of their learning. Informal training and education facilities should be made available so that they can receive training in vocations to empower them as not everybody can get a place in the white-collar job market. These women can train to become hairdressers, nutritionists, caterers,

⁶⁰Lenya, C.A, Lenya, R.L, Aduwa, PA, Kaduwa. C.O, 2002. Dissemination of HIV/AIDS Information to Disabled Pupils/Students in Kenya,

⁶¹International Conference on AIDS, TAPWAK, Nairobi, Kenya

Ibid 57

fashion designers, small entrepreneurs etc. They should also be taught skills like management, marketing, advertisement and financial accounting and reporting to assist them to run their businesses. There should be representative groups for these women in the informal sector who can offer community based training. More funding should be invested to set up these training institutions with emphasis being put on the importance of the informal sector to the economy.

- Education is power. Consequently, the government should set a target for the minimum level education that women in this country should attain. Access to education should be equal in all regions without discrimination. In addition to provision of free primary and secondary education, the authorities should ensure that all educational institutions are safe havens for the girls.
- A lot of sexual abuse goes on in schools today and has led to many girls dropping out before they have attained enough education to empower themselves in life. This is mostly due to girls ending up pregnant after sexual favors given to teachers in order to pass exams or through enticement. Due to the shame that they go through, many girls end up not resuming school. While the girls go home and become domestic servants, the perpetrators of the crimes go scot-free since many girls are either too scared to name the perpetrators or nobody listens when they report the crimes. Such injustices need to be addressed by legislators and law enforcement officers.
- Improved quality management of free education should be established as well as creation of viable and transparent reporting mechanisms. There should be an increase in the number of schools to enable more girls to join schools; employment of more teachers and the teacher student ratio should be made more sustainable. Free education facilities and books should also be afforded to adult women who are illiterate or who left school prematurely, to empower them. This will go a long way in decreasing poverty and its consequent ills.
- Parents should be sensitized on the importance of taking their girls to school, especially in communities that still believe that females are supposed to be groomed for motherhood and domestic chores. Those that force their girls into early marriage or FGM should be prosecuted

RIGHT TO EQUITABLE REPRESENTATION OF WOMEN

3.0 Introduction

The 3rd Millennium Development Goal (2000) calls for the promotion of gender equality and empowerment of women. Beijing Platform for Action (BPFA) outlines the right to representation and participation in decision making as a critical area of concern for women.

In the International Conference on Population and Development (ICPD-1994), chapter four on gender equality, equity and empowerment of women pointed out that:

“The empowerment of women and improvement of their status are important ends in themselves and are essential for the achievement of sustainable development. The objectives are: to achieve equality and equity between men and women and enable women to realize their full potential; to involve women fully in policy and decision-making processes and in all aspects of economic, political and cultural life as active decision-makers, participants and beneficiaries; and to ensure that all women, as well as men, receive the education required to meet their basic human needs and to exercise their human rights.”

Although women make up 52% of the Kenyan population, they remain largely under-represented in political and decision-making processes. Table 3.0 clearly outlines that in Parliament today, out of 222 members only 18 are women, 10 elected and 8 nominated. The level of under representation manifests itself further when we look at the ministerial and other dockets. Only 2 out of 34 Ministers are women, just 6 out of 46 assistant ministers are women, 7 out of 34 permanent secretaries, only 2 out of 71 DCs are women, just 15 out of 45 ambassadors are women and a mere 12 out of 44 are high court judges. This needs to be addressed in order to engender leadership in this country.

The issue here is not the actual numbers but the incorporation of women's needs and wants in the country's decision-making processes in all areas so that their human rights are not neglected. Gender mainstreaming should be encouraged in all sectors and appointment of leaders should be done equitably to actualize gender equality and empowerment.

3.1 Health factors

Chapter seven of the International Conference on Population and Development (ICPD) - 1994 on reproductive rights and reproductive health pointed out that:

“Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescents, men and women. Such programmes must both educate and enable men to share more equally in family planning, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STDs.”

Table 3.0: Gender representation in politics and decision-making positions from June 2003 to January 2007

Year	2003	2005	2007
Women	18	18	18
Men	204	204	204
Total	222	222	222
Women Percentage (%)	8.1	8.1	8.1
Year	2003	2005	2007
Women	3	3	2
Men	26	26	32
Total	29	29	34
Women Percentage (%)	10.3	10.3	6
Year	2003	2005	2007
Women	4	4	6
Men	39	39	40
Total	43	43	46
Women Percentage (%)	9.3	9.3	13
Year	2003	2005	2007
Women	3	6	7
Men	21	25	27
Total	24	31	34
Women Percentage (%)	12.5	19	20.5
Year	2003	2005	2007
Women	3	2	2
Men	68	69	69
Total	71	71	71
Women Percentage (%)	4.2	2.8	2.8
Year	2003	2005	2007
Women	7	11	15
Men	27	29	30
Total	34	40	45
Women Percentage (%)	20.6	28	33
Year	2003	2005	2007
Women	9	8	12
Men	42	57	32
Total	51	65	44
Women Percentage (%)	18	12	27

Source: The Ministry of Gender, Sports, Culture and Social Services

3.1.1 Decision-making

Increased representation of women issues should be included and women involved at the decision-making panels with regards to reproductive health, i.e. maternal and adolescent health and all that appertains to them since decisions made there affect women more.

3.1.2 Infertility

Everybody has the right to bear children and found a family. Women should have benefit to all technology to assist them to exercise this right, which includes access to assisted reproductive technology (ART). The task force commissioned by the Ministry of Health to create guidelines for the use and access of this vital reproductive technology in Kenya, should therefore have an equitable number of women representatives.

3.1.3 Sensitization of religious institutions

More women should be involved in decision making in religious institutions regarding policies on reproductive health issues e.g. family planning, abortion, sexual abuse and rehabilitation. This will sensitize those making decisions on the pros and cons of the doctrines imposed on women by the various religious practices and they will then be able to amend, revise and abandon practices that are harmful, e.g. policies prohibiting family planning methods and female genital mutilation. Religious institutions play a big role in the decisions of the congregation; if their leaders embrace and promote healthy reproductive health decisions, equality and empowerment of women, they will be able to influence their congregation to do the same.

3.1.4 Hazardous cultural practices

Women's voices should be heard in the communities that practice harmful traditions. They should be more actively involved in developing alternative methods of initiation into adulthood and in proactive approaches to eradicate harmful cultural practices such as early child marriage and widow inheritance.

3.1.5 Budget allocation by government for Reproductive Health (RH) services

Budget allocation to this department should be increased in order to have more women accessing their right to health. More women should be involved in decision-making on funds allocated to RH services, and the priority areas to be addressed.

3.1.6 Access to information on RH for both adolescents and women

Censorship boards have mostly been prejudiced against youth and women and information on reproductive health and sexuality since there is no national media policy or guidelines that address the issue of gender in Kenya. However, due to intense lobbying by activists, individual media houses have to some degree tried to incorporate gender perspectives particularly in the print media where the two main national newspapers have over the last few years made a conscious effort to increase coverage of gender issues. Special coverage to women has been given on the world women's day in all mass media in the country. Oftentimes the print media has run yearlong campaigns on issues like Domestic violence and Rape.⁶²

There should be more women in the censorship boards to avoid hindering access to accurate RH information. A recent appointment (October 2007) by the Information and Communications Minister of the censorship board saw only 3 out of the 8 appointees being female. Understaffed

health facilities and lack of proper training for available staff on RH issues is also proving a major hindrance for women to access quality reproductive health care. More staff needs to be empowered through training to provide these RH services more effectively and efficiently. Concerning lack of information on antenatal, delivery, postnatal care and infant/child nutrition; empowerment of women on these issues through education and sensitization campaigns is vital.

3.1.7 More representation of women and gender in on going health sector reform

There should be promotion of National Social Health Insurance Fund (NHSIF), which will also empower women after retirement. On healthcare financing more budgetary allocation to RH and women specific health programmes could go a long way in helping women access their RH rights. The Ministry of Health should make better use of retired nurses and health workers in order to make access to health care more viable for women on the grassroots. They should be integrated in national health plans by paying them under existing health care structures, to enable them to earn a better living and contribute to the reduction of maternal and infant mortality by giving delivery and postnatal care in marginalized areas, and communities where home deliveries are preferred for cultural or spiritual convictions.

3.1.8 Parliamentary representation

More women parliamentarians will result in better representation of women's issues pertaining to their health, economic status, cultural status, as well as providing valuable representation on matters pertaining to their children (the youth). This will consequently lead to development of policies and infrastructure that better caters for women and girls reproductive health rights.

3.2 Education factors

Chapter eleven of the ICPD-1994 indicates that:

“The increase in the education of women and girls contributes to women's empowerment, to postponement of marriage and to reductions in family size (reducing poverty). When mothers are better educated, their children's survival rate tends to increase.” This is because educated women are better equipped with better nutrition knowledge, better hygiene, and frequently access medical care both before and after child delivery.

A girl without education becomes a woman vulnerable to the risks of unhealthy childbearing patterns, who is less empowered in decision-making and with limited access to resources both in private and public spheres.⁶³ Girls in Kenya now make up 48% of total primary and secondary school enrolment. However 85% of young women enrolled at some point have dropped out of school by the age of 20 years.⁶⁴

3.2.1 Representation in schools

There should be more women in school and parent boards so that policies on girls who become pregnant while in school and bursary allocation to girls can be implemented. The Ministry of Education dictates that each school BoG/PTA should have at least 1/3 women representation regardless of their literacy levels, to ensure equitable representation of the concerns of female students. With regards to orphan headed homes; there should be flexibility regarding girls that have to contend with bearing parental responsibility, in matters pertaining to exams, learning, tuition and counseling, fees, to enable them to achieve education as they cope with absenteeism, domestic chores and financial burdens. Further, disabled children/girls need special representation in order to guarantee proper policies contributing to their access their right to education.

⁶²Dorothy Otieno (Journalist), 2002. Policy approaches as enabling framework

⁶³Ibid 4

⁶⁴Ibid 55

3.2.2 Ministry of Education's quota system

The current quota system should be reviewed so that girls from regionally discriminated areas do not miss out on secondary and university education. With more women representation we should be able to get more girls to enroll and complete secondary school. The Kenyan Government is aiming to increase the percentage of children who move on from primary to secondary education from 47% to 70% by 2008, with a special focus on girls' education. This will present a significant challenge, since the fees charged by secondary schools are much higher than those charged by primary schools. 'National' level secondary boarding schools cost around £450 per year, which is prohibitive for most rural Kenyans.

3.2.3 Media, information and communication

Despite the importance of reproductive health in Kenya, and in Africa generally, the media is often ill equipped to provide information required by the public and policy-makers. There are four possible reasons for this.

1. There are often poor linkages between the media and the scientific and research community.
2. Journalists and editors may not be sensitized to the need and demand for information on reproductive health.
3. Given the dominance of coverage on HIV/AIDS, many important reproductive health concerns are ignored or not given sufficient coverage.
4. Many journalists who cover reproductive health simply do not have sufficient skill in presenting and analyzing issues and events related to reproductive health.

Some media houses have however played a big role in publishing stories on public health frequently and some have devoted special newspaper issues, and air time to specific issues such as HIV/AIDS and malaria. Special features and documentaries raise awareness about reproductive health issues from a human-interest perspective. Also they have played an important role in popularizing previously taboo subjects for example, demystifying sex, HIV/AIDS, contraceptives etc. An emerging role of the media has been to act as an interface between the public, government agencies and professionals.

However some reporting has been sensationalized to focus on profit making and in most cases waited until public health matters have become national disasters and thus big news before broadcasting. Media houses should instead act as a preventative medium. There is lack of adequate investment in RH investigative journalism and there has been a bias towards urban areas at the expense of rural areas. Hence Kenyan media face many challenges in improving their ability to better report on reproductive health. What is required is a more proactive approach by media houses to develop the skills and expertise required.⁶⁶

3.2.4 Training of border police

This should be carried out in order to detect cases of human trafficking especially for sexual exploitation and enable them to take the necessary action.

3.2.5 Training and information on reproductive health in health facilities

These facilities should be integrated even in the most remote rural areas so that girls and women can easily access them. Retired health care workers and community based birth attendants and social workers should also benefit from training on reproductive health issues and empower them with appropriate information which can be disseminated at the grassroots level.

⁶⁶InspireKenya, 2006. <http://inspirekenya.com/Education%20sector.pdf>

⁶⁷Rosemary Oralle-Okelo, 2004. <http://www.genderlinks.org.za/docs/amalungelo/amadocs7/challenges%20media%20struggles%20with%20reproductive%20health.pdf>

3.2.6 Adult education

Structures for enforcing adult education should be formalized so as empower illiterate women especially at the grassroots level on their health, education and legal rights. In order for this to be achieved, there is a need for interventions and improvement of existing structures at the community level such as women groups and the religious and cultural institutions.

3.2.7 Police force/help desks

Police officers should be trained on women rights and gender sensitivity. This will entail proper training for such officers to enable them help in cases of sexual and gender based violence. Such officers should also receive training on administration of post-trauma counseling.

3.3 Legal factors

3.3.1 Discriminatory laws

Statutory provisions and legal practice that amounts to or condones discrimination of women e.g. in matters of inheritance, sexual abuse, age of marriage for girls etc. should be reviewed or altogether repealed to ensure that there is equality before the law and that the laws are more representative of all the groups in the population. Higher representation of women in Parliament would ensure that these laws are reviewed accordingly and future gender sensitive policies are crafted in line with international standards and instruments to which Kenya is a party.

3.3.2 Religious restrictions

Some African communities' and some Islamic groups accept child marriages, and harmful practices such as FGM as part of their religion. Some Christian denominations also discourage the use of all or certain methods of family planning. There is need for the government, civil society and partners to initiate structured dialog with these institutions, as well as to sensitize more women on the need to speak up against violation of their rights under the constraints of religious ideologies. Religious leaders need to be sensitized on the adverse effects of these issues on women they should give some leeway for women's opinions, which will better their access to their right to health.

Affirmative Action Bill

This draft legislation was rejected by a male dominated Parliament. Better representation of women would have ensured that The Affirmative Action Bill was passed. Furthermore, it should be understood that 50 seats reserved for women in parliament equals only 16% of representation for women, contrary to many uninformed allegations that women would be over-represented. Another blow to the affirmative action movement was the dismissal of the Constitutional Amendment Bill for Affirmative Action. Further education involving youth, men, women and leaders needs to be done from the grass roots up to the parliament, to demystify affirmative action and remove misconceptions related to it, to ensure better reception and implementation of this idea to empower marginalized groups within the society. Further more, many Kenyan leaders are beneficiaries of Affirmative Action provided for after independence by the British colonial regime. Therefore, borrowing from the Somalia experience,⁶⁷ Kenya needs to entrench affirmative action into the current constitution so that the prejudices that have existed against the minorities and women can be remedied and overcome.

⁶⁷Somalia is one of the most equitably represented states in Africa, with women comprising over 40% of parliamentarians.

3.3.4 Sexual Offences Act

During the debate leading up to the Sexual offences Act (2006), most male Ministers in Parliament rejected the sections criminalizing marital rape, FGM, and watered down clauses including those dealing with sexual harassment. In addition the Act contains serious loopholes in some provisions such as sections 32, which deal with false accusations, and provisions on deliberate transmission of HIV/AIDS. With better representation of women, there would be a bigger quorum to pass more favourable legislation and developed policies and implementation strategies on matters mainly afflicting women and children sexual reproductive rights.

3.4 Recommendations

There is need to engage in non-confrontational dialogue with all stakeholders and duty bearers, so that issues relating to women and girls can be prioritized and resolved. For the religious sects that for example feel that modern contraception is unacceptable, they need to listen to the statistics that show that traditional methods are far outweighed by modern ones. For those that feel that FGM is a ritual that signifies adulthood and maturity, they need to be educated on the ill effects of the practice to encourage them to create alternative less intrusive and dangerous rites of passage.

Bills being debated in Parliament that are entrenched on Affirmative Action should be approached with impartiality and sensitivity. It should be understood that this action is not bent on men losing their power as leaders in office and in their homes. It is meant to break the bondage that has oppressed many women in this country. Human rights define the basic, inalienable and accepted standards and protections that every human being should live within, in dignity. The violation of women's rights should therefore never be tolerated and real actions taken to eliminate such violations.

LEGAL COMPONENT

4.0 Introduction

Equality before the law and equality of the law are basic tenets of jurisprudence and the hallmark of any truly democratic society. Systems and structures that necessarily create the space for citizenry to exercise and enjoy their rights and freedoms are paramount in achieving socio-economic equality through provisions that elevate the status of marginalized and discriminated constituents. In Kenya the legal status of women and girls continues to remain in a pitiable state despite Kenya being party to International instruments, which bind it to create, and implement legislation and policies geared towards elimination of all forms of discrimination (whether cultural, political or otherwise) against the woman and the girl child.

Although existing legislation in Kenya ostensibly offers equal protection of the law to all citizens there still remains lacunae in many provisions and this coupled with lethargy of Parliament to amend existing statutes in order to bring them up to date with the dynamics of an ever evolving society translates to Courts implementing draconian provisions which do little to protect the woman and girl child in Kenya.

The lack of political will to domesticate salient provisions in Regional and International instruments to which Kenya is a party such as the Beijing Platform for Action, the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), The Optional Protocol to the African Charter on Human and Peoples Rights etc, also contributes to the dismal legislative framework within which rights seekers and duty bearers operate.

An inadequate legislative framework compounds the myriad of problems that women and the girl child face in Kenya today. The absence of equal right of meaningful participation in decision making structures, equal right of representation and freedom from discrimination all serve to disenfranchise the woman and girl child from the exercising and enjoyment of their fundamental rights.

Access to justice for women and the girl child is undermined by lack of an appropriate inter-phase between women and the judicial system. Scarcity of resources, ignorance of legal provisions, corruption in the judiciary and public offices in general such as local authorities and police force, coupled with patriarchal attitudes and harmful cultural practices all contribute to the bleak construct within which women and the girl child are expected to operate.

4.1 Analysis of existing legislation vis-à-vis women and the girl-child

4.1.1 Constitution of Kenya

The Constitution of Kenya is the Supreme legislation through which all other laws emanate and aside from creating and safeguarding fundamental rights of citizens it also determines and regulates the legal relationship between citizens and the State and between citizens themselves.

Section 82 (1) of the Constitution provides that no law shall make any provision that is discriminatory either of itself or in its effect.

Section 82(2) read together with section 82(3) provides for and safeguards against discrimination on the basis of race, color, sex, etc.

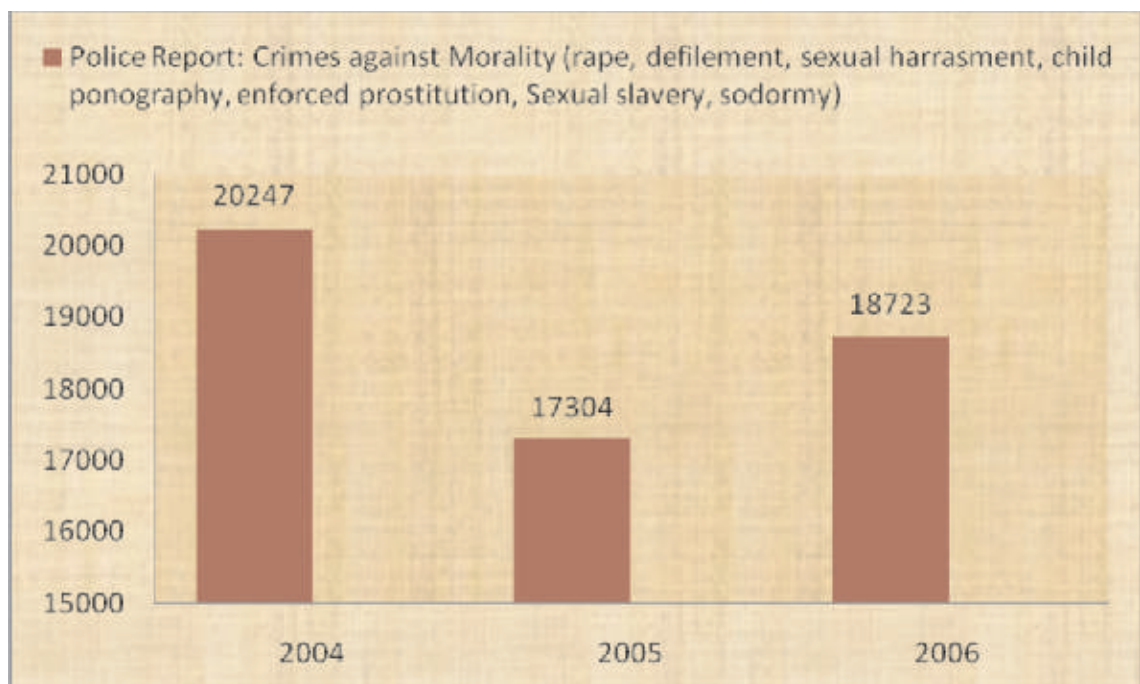
Section 82(4) however is a claw back clause, which works against the spirit of section 82(1) and 82(2) & 3 which states that the Constitution allows for discrimination on matters relating to burial, marriage, and divorce, devolution of property on death or other matters of personal law. This then begins to inform the basis of many harmful cultural practices which women fall victim to and unable to seek redress from.

4.1.2 Gender Based Violence

Violence against women persists in every country in the world as a pervasive violation of human rights and a major impediment to achieving gender equality. Statistics on all forms of violence in both public and private life against women in Kenya remains inadequate though it remains a problem that needs to be dealt with in great urgency.

There has been an attempt to push for the Domestic Violence and Family protection Bill to be enacted into law, but the bill is still pending in Parliament for further deliberation. Currently, one can still go to court using the Penal Code for a case of assault. If it is a case of Cruelty, then one can move to court for divorce using the Marriage Act and the African Christian Marriage and Divorce Act, or the Matrimonial Causes Ordinance if it is based on a Christian marriage; the Mohammedan Marriage and Divorce Registration Act, if its based on a Muslim Marriage; and Hindu Marriage and Divorce Act for the Hindus.

Violence against women is recognized as a human rights violation in many agreements and international and regional treaties and national commitments, which should be useful as tools and real guarantees to work towards the prevention of these crimes. As an example, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its Optional Protocol, 1979/1999, which calls on States to pursue a “policy of eliminating violence against women” and empowers women to make demands at national level and make their demands to be taken into account; the United Nations (UN) Declaration on the Elimination of Violence against Women, 1993; the chapter devoted to violence against women in the Beijing Declaration and Platform for Action adopted by the UN World Conference on Women, 1995; the Rome Statute of the International Criminal Court (ICC), 1998, which includes sexual violence rape, sexual slavery, enforced prostitution, forced pregnancy within the definition of crimes against humanity and war crimes; the Beijing review (Beijing +5) that calls for the criminalization of violence against women and for the adoption of measures to end violence against women on the basis of racial grounds and included honour crimes for the first time; the United Nations Millennium Declaration, 2000 that proposes “to combat all forms of violence against women”, as well as to support some of the above-mentioned conventions.



4.1.3 The Penal Code Cap 63 laws of Kenya

The Penal Code is an Act of Parliament that establishes a code of criminal law. It safeguards women and children under the Chapter dealing with offences against morality, which outlines various offences and punishments for sexual offences such as rape and defilement. However with the enactment of the Sexual Offences Act 2006, the provisions in the penal code relating to sexual offences have since been repealed and are now more comprehensively dealt with the new legislation.

Why do we need the Sexual Offences Act?

The Sexual Offences Act 2006 is an Act of Parliament that makes provisions about sexual offences, their definition, prevention and the protection of all persons from harm from unlawful sexual acts, and for connected purposes. While the Penal Code and the Criminal Law Amendment Act of 2003 has provisions for dealing with sexual offences. However, those provisions have been inadequate in responding to a crime that continues to grow in magnitude while the perpetrators become more sophisticated in their approach in committing the offence.⁶⁸ Almost all-violent crime is now accompanied by the offence of rape while the ages of survivors range from 3 month old babies to 80 year old women. This has created the need for a more comprehensive law to address the rising incidence of sexual violence.

The Act domesticates the provisions of a number of conventions, including the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the United Nations Convention on the Rights of the Child (CRC).

In respect of the rights of women, the provisions of the act need to be measured according to the provisions of CEDAW. One of these is Article 6, which provides that:

“States Parties shall take all appropriate measures, including legislation,
To suppress all forms of trafficking in women and exploitation for prostitution of women.”

4.1.4 The Sexual Offences Act and the Convention on the Rights of the Child

Construed against the Convention on the Rights of the Child, the Sexual Offences Act, 2006 makes the following provisions, which were previously non-existent in Kenyan law. Article 1 of the Convention requires that every person be considered a child if the person is below the age of eighteen years. This is implemented in section 2 of the Act that defines a child in conformity with the Children's Act, 2001 (which gives an age of 18 years and below).

Article 11 of the Convention requires State Parties to take measures to combat illicit transfer and non-return of children abroad. This is implemented by section 13 of the Act, which outlaws child trafficking while section 14 of the Act outlaws child sex tourism.

Article 34 of the Convention requires State Parties to protect the child from all forms of sexual exploitation and sexual abuse. In particular, State Parties are required to take appropriate measures to prevent:

- a) The inducement or coercion of a child to engage in any unlawful sexual activity (Section of the Act 8 outlaws defilement; section 9 outlaws attempted defilement; section 11 criminalizes indecent acts with a child and section 12 outlaws the promotion of sexual offences with children);
- b) The exploitative use of children in prostitution or other unlawful sexual practices (Section 15 of the Act criminalizes child prostitution);
- c) The exploitative use of children in pornographic performances and materials (Section 16 of the Act criminalizes child pornography).

⁶⁸<http://www.kenyapolice.go.ke/resources/COMPARATIVE%20FIGURES%202004,2005%20AND%202006.pdf>

Article 35 of the Convention requires State Parties to take appropriate measures to prevent the abduction of, sale of or trafficking of children for any purpose or in any form while article 36 of the Convention requires State Parties to protect the child against all other forms of exploitation prejudicial to the child's welfare. This is implemented by section 13 of the Act, which outlaws child trafficking while section 14 of the Act outlaws child sex tourism.

Highlights of the Act

- 1 It consolidates various offences of a sexual nature into one comprehensive law.
- 2 The act defines comprehensively various offences that are of a sexual nature and prescribes varied sentences to those offences.
- 3 It is gender inclusive and offers redress to men and women, boys and girls contrary to the view that it is a law by "women to fix men".
- 4 It provides for minimum sentences, which is a first in Kenyan law making. This is significant, as it no longer leaves the issue of sentencing in offences of sexual nature to the discretion of the court. In the past persons found guilty of crimes of a sexual nature have been sentenced to lenient sentences such as probation and that is clearly not a deterrent. It expressly provides for persons with disability S 7 & s 19 as a distinct category requiring special protection owing to their higher degree of vulnerability.
- 5 Creates sexual offences relating to persons in position of authority and trust.
- 6 It creates and details various sexual offences against children that were previously not catered for under the law.
- 7 It extends liability to other legal persons like companies and expressly provides sentences for them.
- 8 It repeals certain sections in the penal code and creates new offences

Challenges in the Act

The Act has a number of technical challenges such as inconsistencies with some of the provisions in the Penal Code for example the definition of Rape in the Sexual Offences Act has been enlarged to cover the offence of sodomy however the corresponding provision in the Penal code has not been repealed leaving 2 Acts which now provide for this offence

The act also suffers from errors in drafting of some of its clauses which leaves gaps for manipulation example the definition of Rape in section 3 and section 16 which is headed "child prostitution " but makes no reference to a child in the substantive provision.

Other gaps include Section 23 dealing with sexual harassment which makes only persons in position of authority or public officers liable for harassment. Section 38 making it a criminal offence to make 'false allegations' is open to manipulation and can be turned around to victimize survivors of sexual violence, and deter them from seeking justice. In addition marital rape has not been recognized nor criminalized under the Act.

Recent judicial decisions in sexual offences cases reported in the Daily Nation 24th February 2007 where a High Court quashed a sentence against a man who had been sentenced for Rape on the basis that the complainant never told her parents or close relatives about the rape. Similarly on 14th August 2007 it was reported that a 40 year old man in Kilifi who had been defiling his daughters aged 4 and 5 was sentenced to 5 years in prison while the Sexual Offence Act clearly prescribes a mandatory life sentence!!

Implementation of the provisions in the Act

Although the Act has very powerful provisions such as those that provide for the protection of vulnerable witnesses, these provisions are yet to be implemented.

Ignorance of the provisions in the Act remains a challenge and although organizations like CREAM are involved in civic awareness and simplification of the Act. However, lot of work remains to be done in training judicial officers, police and local authorities.

4.1.5 The Marriage Act⁶⁹ & the African Christian Marriage and Divorce Act⁷⁰

In Kenya the Marriage Act provides for couples that wish to conduct a statutory marriage while the African Christian Marriage and Divorce Act provides for formalization of traditional marriages. Interestingly foreigners cannot conduct a marriage under the African Christian Marriage and Divorce Act as it only applies to 'Africans'. However cohabitation has also been accepted through judicial decisions as a presumption of marriage and this offers some protection to women who are not married either customarily or under statute.

There is however no provision for registration of customary marriages or for registration of "come we stay" marriages. This implies that such women (especially those cohabiting) are not recognized as wives of the deceased unless for purposes of inheritance and even then only if they have children with the deceased.

Division of matrimonial property

A suit for division of matrimonial property must be instituted during the subsistence of a marriage as it is done under the Married Women's Property Act of 1882. Appeal court decisions in the cases of *Kivuitu vs Kivuitu* and *Muthembwa vs Muthembwa* have maintained that upon dissolution of marriage a woman is entitled to 50 % of the matrimonial property. The rationale behind this was that even where a wife has not contributed financially to purchase of property or goods, her expending of time and energy in improving the matrimonial home and or giving birth to and taking care of the children is seen as contribution enough.

The recent Court of appeal ruling in *Echaria vs Echaria (Peter Mburu Echaria vs Priscilla Njeri Echaria Civil Appeal No 75 of 2001)* has however revisited the issue of contribution and states that only financial contribution is taken into consideration in division of matrimonial property suits.

4.1.6 Property Rights

The succession Act is an Act⁷¹ of Parliament to amend, define and consolidate the law relating to interstate and testamentary succession and the administration of estates of deceased persons and connected purposes. Section 35(1) on Laws of Succession⁷² provides that where a spouse dies interstate leaving a surviving spouse and a child or children, the surviving spouse shall be entitled to the personal and household effects of the deceased absolutely; and a life interest in the whole residue of the net interstate estate.

The Law of Succession Act continues to state that if the surviving spouse is a woman, that interest shall determine upon her re-marriage to any person. This in itself is discriminatory, as it does not apply to the man when he remarries. Section 35(5) of the Laws of Succession, provides that when someone dies interstate, the property shall devolve to the surviving child or equally be divided among the surviving children without making distinction as regarding the sex of the child. Though there is a trend toward recognition of rights of the girl child, many courts still disregard this provision and discriminate against the girl child. The discriminatory provisions in the succession Act have their genesis in Section 82(d) of the Constitution of Kenya, which allows discrimination on matters of personal law including inheritance and succession.

Section 32 of the Succession Act provides that the provisions of the Act shall not apply to agricultural land or crops thereon or to live stock, which is situated in such areas, as the minister shall by notice in the Gazette, specify. Section 33 then provides that the law applicable, to the distribution on intestacy, of the categories of property specified in section 32 shall be the law or custom applicable to the deceased's community or tribe as the case may be.

⁶⁹Cap 150 Laws of Kenya

⁷⁰Cap 151 Laws of Kenya

⁷¹Cap 160 Laws of Kenya

⁷²Cap 160 Laws of Kenyaz

The gist of these two provisions is essentially to remove application of the Succession Act in certain areas that have agricultural land and allows the customary practices with relation to inheritance in those areas to take precedence over the Act. The import of this is that women living in such area often miss out on the opportunity to inherit property from their parents or their deceased husbands especially where customary practices do not allow for this. Such women have no recourse in law as the Succession Act and the Constitution guarantees the right to such discrimination.

A lot of discrimination against women and the girl child also take place with complaints from men of double inheritance by women of property (i.e. From their fathers as well as from their husbands). Personal law is also often invoked and is used as a basis of discrimination against women and the girl child.

The succession Act also conflicts with the Marriage Act Cap 150 as it (the Succession Act) acknowledges the second wife of a statutory marriage as a wife for purposes of inheritance while the Marriage Act clearly provides that such a second wife is not a legally recognized wife.

4.1.7 Abortion

The issue of abortion has continued to be debatable up to date. The laws on abortion vary from country to country. The Protocol to the African Charter on the Rights of Women in Africa which is the first legally binding human rights instrument to expressly articulate women's reproductive rights as human rights and to expressly guarantee a woman's right to control her fertility. Specifically, the protocol is the first human rights instrument to expressly articulate a woman's right to abortion in specified circumstances.

Article 14 (2) (c) provides that State parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

By signing these conventions, the Kenyan government has committed itself to ensuring the highest standards of reproductive health information and services to its women. Kenya has however not ratified this Protocol and has therefore not domesticated its provisions

In Kenya abortion is a criminal offence. The penal code prohibits abortion.⁷³ This is in relation to the person who aborts a pregnancy and anyone who helps in carrying out an abortion. It is worrisome that abortion is not legal in Kenya despite shocking statistics that indicate extremely high cases of high morbidity and mortality associated with unsafe abortions.

Sections 158 to 160 of the Kenyan Penal Code Cap 63 criminalizes the use of noxious substances, poisons or force to procure an abortion on another person, oneself and also persons who deal in drugs or equipment used in the procurement of abortion respectively

Section 240 of the Penal Code however provides that *abortion is permitted only for the "preservation of the woman's life"*⁷⁴ as stated in Section 240 of the Penal Code - "A person is not criminally responsible for performing in good faith and with reasonable care and skill surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case."

4.1.8 Female Genital Mutilation

In Kenya, many children continue being forced to undergo genital mutilation, which is a violation of their sexual right. For a long time there had been no law protecting the girl child from hazardous rituals such

⁷³Section 158-160 Cap 63 Laws of Kenya

⁷⁴Section 23 Sexual Offences Act

as FGM. However with the passing of the Sexual Offences Act, Section 29 prohibits the act of forcing a person to take part in a sexual act for cultural or religious reasons. This is important in helping to curb out harmful cultural practices like early child marriages and cultural rites of passage. Further, the Children Act⁷⁵ bans FGM on girls younger than 18 years.

Kenya has signed international charters and conventions that guarantee that every person has the right to health and the right to be free from violence, for example the United National Universal Declaration of Human Rights. Other conventions improved the protection for women and children, like the Convention on Elimination of All Forms of Discrimination Against Women and the Convention of the Rights of the Child.⁷⁶

Article 1 of the African Protocol on Rights of Women defines the term harmful practices to include attitude, behavior and practices, which fundamentally affect the rights of women and girls negatively. These conventions clearly state that FGM is a harmful traditional practice that is against human rights, against the rights of the child and against women's rights to health. In addition, many African countries have passed laws to ban the practice of FGM.⁷⁷

According to official statistics (Kenya Health Demographic Survey 2003), overall, 32% of Kenyan women are circumcised. This is a sizable decline from 38% in 1998 to 31% in 2003 (excluding the northern districts). Age comparisons also support this trend: 48% of women age 40-49 are circumcised, compared with 25% of women age 20-24 and 20% of women age 15-19.

Female genital cutting varies widely by residence, province, and ethnicity. Circumcision is more common in rural areas (36%) than urban areas (21%). Western Province has the lowest rate of female circumcision (4%) and North Eastern has the highest rate (99%). Certain ethnic groups practice female genital cutting more frequently; the Kisii, Maasai, Somali and Kuria all have circumcision rates above 90%, while women from the Luo and Luhya groups have rates of less than 1%.

Female genital cutting is strongly related to educational level. Women with no education are almost three times more likely to be circumcised (58%) than women with at least some secondary education (21%). A similar pattern is seen with wealth: women in lower wealth quintiles are more likely to be circumcised.

The Children Act of 2001 criminalizes FGM in section 14 and Section 115, which gives the civil right to anyone who comes across a girl under threat of being circumcised, to move to court. The Children Act domesticates article 19 of the Convention of the Rights of the Child:

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Curiously the provisions in the Children Act do not prescribe a sentence and section 14 only criminalizes FGM but does not prescribe a punishment for it, making enforcement impossible and haphazard. Various reports from the grassroots have begun to show a disturbing trend in female genital mutilation where practitioners of the same have "sanitized" it by practicing it in hospitals. One of the biggest challenges in curbing FGM is that it is rooted in cultural practices of very many ethnic groups.

4.1.9 Citizenship

Under the Constitution, a Kenyan man can pass citizenship to his foreign wife.⁷⁸ However this is not the same position as regards to Kenyan women who are married to foreign men. Further, a Kenyan man married to a foreign woman can pass the Kenyan citizenship to his children⁷⁹ but a Kenyan woman cannot pass citizenship to the children as they take up citizenship from their father. Currently in the ongoing minimum constitutional reforms there is a Bill laid in parliament that is subject to deliberations in the National Assembly for the incorporation of dual citizenship in the Constitution. If the ongoing talks are prosperous then the Bill will be enacted into law.

⁷⁵Act no 8 of 2001

⁷⁶Article 24 (3): The right to be protected from harmful practices

⁷⁷African Charter on Human and People's Rights 1981 and the African Charter on the Rights and Welfare of the Child, 1990

⁷⁸Section 87 and 90 of the Constitution

⁷⁹Section 88 and 91 of the Constitution

4.2 Recommendations

In the face of the myriad of challenges that women and the girl child face in society, it is paramount that application of laws begins to be on an equal basis and that gaps in existing legislation are cured in order to facilitate protection of the enjoyment of fundamental rights for women and the girl child. Inconsistencies in existing legislation and the Constitution must be cured to allow for equality before the Law. This will also necessarily cure conflicting provisions in the existing legislation.

Kenya must as a matter of urgency ratify International and regional treaties to which it is a party to enable implementation of provisions that are intended to improve the status of women and girls in Kenya including the Maputo Protocol to the African Convention on Peoples and Human Rights.

The Government along with Civil societies must engage in strategies and approaches that build on each others strengths to allow for maximum use of resources in disseminating information on human rights at grassroots level and in institutions of learning. The right to information is a sacrosanct right, which must be safeguarded in order for Kenyans to be enlightened on their rights and hold duty bearers accountable for the same. There must also be as a matter of urgency more inclusion of women in decision-making structures so as not to disenfranchise women from the process of formulating policies, which affect them and the enjoyment of their fundamental rights. Currently out of 222 members of parliament there are only 18 women, which is a dismal number by any standards and especially in a country that boasts of democracy. Kenya currently lags behind its neighbors Tanzania, Uganda Rwanda and South Africa in implementing affirmative action.

Economic growth in the Country must also be linked closely with the well being of women and the girl child. The government must be able to appreciate the value added to growth in the economy through informal sectors, which are mainly operated by women. This alone should be incentive for Government to ensure the well being of women through domesticating provisions in international instruments to which Kenya is a party and which are aimed at elevating the status of women and the Girl child.

There exists a great gap between urban and rural coverage and availability of gender violence recovery services. The magnitude of the sexual violence in Kenya and resource constraints makes it impossible for hospitals that provide free treatment to sexual or physical assault to cater for all victims within the country. An even greater restriction is that most access is limited to victims within urban areas where there are many health centres, and the rural communities are both unaware and unable to conveniently access the recovery services due to the remoteness and far distances to health centres. Community awareness programmes should therefore be scaled up to address the dissemination of this vital, as well as life saving information to women and potential victims.

Community sensitization is crucial to instigate the change of social attitudes towards domestic violence, and to educate the communities about women rights and the criminal nature of domestic violence. Training for police officers especially those manning 'gender desks' should be scaled up. Neighborhood watch programmes can also be adopted to bring to light domestic violence and to rescue victims undergoing abuse in the domestic spheres. There is also an urgent need to create shelter and rehabilitation centres for these victims.

To reduce trafficking of girls and women, especially for sexual exploitation and forced labour, public awareness and civil society lobbying on the Trafficking in Persons bill which was presented to the Attorney General early this year and is awaiting discussion in parliament should be promoted. Civic education workshops should also be conducted within the target communities to ensure they are aware of their rights, obligations and legal remedies available under the new law to empower them to implement it. There should be training programs implemented to sensitize police, border patrol and immigration officers, medical officers and community leaders on the threat and prevention of human trafficking.

Creation of safer public zones by undertaking street lighting programmes, clearance of garbage and bushes providing hiding areas for assailants. Improving public transport system and its coverage to residential areas to prevent the risk of assault for women commuters and pedestrians.

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