

**ASCERTAINING WHETHER THE REALISATION OF THE RIGHT TO  
REPRODUCTIVE HEALTH CARE IN KENYA IS DISCRIMINATORY AGAINST  
WOMEN.**

**BY**

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**OCTOBER 2019**

**DECLARATION**

I, LINDA WANJIRU do declare that this is my original work and has not been submitted for any award to any Institution or anywhere else before. The sources I have used or quoted have been indicated and acknowledged by references.

Signed.....

Date.....

This research project has been submitted with the approval of my University Supervisor

Signed.....

Date.....

Dr. Nancy Baraza

## **DEDICATION**

I dedicate this project to all women - born into an oppressive system driven by patriarchy that judges them not by the content of their character but by their gender and sexual identity.

## **ACKNOWLEDGEMENT**

First and foremost, I thank the Almighty God for His love and mercy that strengthened my resolve to complete this research project despite surmountable barriers. It is by His grace that I wake up daily to fight for the human rights of all persons. Secondly, I would like to acknowledge the invaluable input of my supervisor Rtd. Lady Justice Dr. Nancy Baraza whose guidance and immense knowledge moulded my writing skills. Secondly, I would like to acknowledge the forbearance and guidance of my colleagues at the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN). Their individual and shared knowledge on all things health, strongly guided the evidence based analysis in this study. I hope it will prove a useful source of information for our continued work on health and quite specifically in SRHR thematic area.

Ultimately, this thesis would not have been completed without the support of my mother, grandmother and partner. I thank them for encouraging me to embrace my feminist beliefs and principles. Onward and upward!

## **ABSTRACT**

Generally, it is held and accepted globally that the Right to Health is a human right and as such it should be provided to all persons indiscriminately. The Constitution of Kenya under the Bill of Rights in Chapter Four Article 43 (1) (a) provides that every person has the right to the highest attainable standard of health including the right to health care services which include RH care. Although this right has been provided for in the constitution, nonetheless, the Kenyan government has opted to realize this right without proper timelines and strategies to ensure that it is eventually realized for every Kenyan. With specific reference to women's reproductive rights, the current implementation has led to an increase in maternal deaths, the continued unavailability of RH services and even rises in cost in some instances.

This Research Project will seek to trace and lay out the various International and National Laws and Policy Frameworks in a bid to identify the hierarchy and importance of women's right to RH care. The paper will also seek to outline and identify the effects of the implementation of the right to RH care in Kenya through an analysis of three RH areas namely; maternal care, access to contraceptives and the right to access safe abortion within the parameters of the law. Finally, the project analyses practices of two countries that have constitutionalized and judicialised the right to RH care in order to draw lessons from their contexts.

By drawing from this evidence, readers will be able to comprehend whether the current implementation of Article 43 (1) (a) of the Constitution of Kenya results in the discrimination for women and girls of reproductive age or is intended to promote their RH and realise their right to RH care.

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*CEHURD v Mulago National Referral Hospital* 212 of [2013] High Court of Uganda at Kampala

*Federation of Women Lawyers (FIDA - KENYA) & 3 Others v The Attorney General & 2 Others* [2015] HC no. 266 of 2015, eKLR

*Isaac Ngugi v. Nairobi Hospital and three others* (Petition no. 407 of 2012, High Court of Kenya) eKLR

*Malachi v. Cape Dance Academy International and Others* [2010] CCT 05/10 ZACC 13 (South Africa Constitutional Court)

*MAO alias MA & MAO v The Attorney General & 4 Others* [2015] HC no. 562 of 2012

*Mathew Okwanda v The Minister of Health & 3 Others* [2013] HC no. 94 of 2012, Eklr

*Minister of Health v Treatment Action Campaign (TAC)* [2002] 5 SA 721 (CC)

*Paola Del Rosario Guzman Albaraccin & Next of Kin v Ecuador* [2008]

*Paton v United Kingdom* [1981] 3 E.H.R.R 408 1980



*Sonia Kwamboka Rasugu v. Sandalwood Hotel and Resort & Another* [2013] eKLR (*Petition No. A56 of 2011 High Court of Kenya*)

## **TABLE OF LEGISLATION**

### **STATUTES**

Constitution of Kenya 2010

Choice of Termination of Pregnancy Act 1996

Makueni MNCH Act, 2015

Public Health Act Cap 242 2012

Sexual Offences Act No. 3 of 2006

The South Africa Constitution 1996

### **INTERNATIONAL TREATIES AND CONVENTIONS**

Abuja Declaration 2000

African Charter on Human and Peoples' Rights 1981

American Convention on Human Rights 1969

Convention on the Elimination of all Forms of Discrimination Against Women 1979

Convention on the Rights of the Child 1989

Declaration on the Elimination of Violence against Women 1967

European Convention on Human Rights and Freedoms 1953

International Covenant on Civil and Political Rights 1966

International Covenant on Economic, Social and Cultural Rights 1966

Protocol to the African Charter on Human and People's Rights on the Rights of Women in  
Africa (Maputo Protocol) 2003

The United Nations Charter 1945

Universal Declaration of Human Rights 1948

World Health Organization Constitution 1945

## **LIST OF ABBREVIATIONS**

ACHPR	African Commission on Human and Peoples' Rights
ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immuno Deficiency Syndrome
CAT	Convention Against Torture
CoK	Constitution of Kenya
CRC	Convention on the Rights of the Child
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
FP	Family Planning
HIV	Human Immunodeficiency Virus
HRBA	Human Rights Based Approach
IACHR	Intra-American Court of Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of all forms of Racial Discrimination

ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic Health Survey
KNCHR	Kenya National Commission on Human Rights
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MMR	Maternal Morbidity Rate
SA	South Africa
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
RDP	Reconstruction and Development Program
RH	Reproductive Health
RHR	Reproductive Health Rights
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
VAW	Violence Against Women
WHO	World Health Organization

## CHAPTER ONE

### AN INTRODUCTION TO THE RIGHT TO REPRODUCTIVE HEALTH CARE<sup>1</sup>

#### 1.0 Introduction and Background

The Right to Health is a human right that is classified as a socio-economic right and should ideally be enjoyed indiscriminately by all. These rights were first recognized as Human Rights in the UDHR article 25<sup>2</sup>. This provision elucidates two very important aspects; the universal provision of the right to health and the importance of reproductive health care for women and girls. As a result, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR) were drafted to create binding obligations towards the realization of individual human rights focused on a wide spectrum of civil and political rights and socio-economic rights.<sup>3</sup>

Currently, only about six percent of Kenya's National Budget is being spent on health<sup>4</sup>, a long way off from its commitment under the Abuja Declaration<sup>5</sup> to allocate fifteen percent of its budget to health. <sup>6</sup> In Kenya, the right is enshrined under Article 43 (1) (a) in the Bill of Rights<sup>7</sup>.

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<sup>1</sup> Reproductive Rights: A tool for monitoring state obligations, Center for Reproductive Rights 2

<sup>2</sup> Universal Declaration of Human Rights (adopted 10 December 1948) UNGA 5Res 217 A (III) (UDHR) art.25 (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including, food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control

<sup>3</sup> Ibid art. 25 (2)

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection

<sup>4</sup> Kenya Economic Survey 2018, Kenya National Bureau of Statistics 246-247

<sup>5</sup> The World Health Organization, Abuja Declaration: 10 Years On (2000)

This study will examine the legal, policy and institutional framework that Kenya has in place to implement the right to health care within the overall framework of the right to health and to assess if implementation has been efficient.

Globally, the right to reproductive health care is an integral part of the right to health enshrined under Article 12 of the ICESCR<sup>8</sup>. This is further reinforced by the adoption of a clearer definition adopted during the 1994 UN ICPD in Cairo<sup>9</sup>. Consensus was reached on the premise that reproductive rights embrace human rights entrenched in national laws, international human rights documents and consensus documents.<sup>10</sup> The provision of the right to health under the ICESCR<sup>11</sup> has allowed for states to take a substantive stand on providing health care services to all their citizens. The creation and adoption of the Covenant by states has been marred by debates on the legitimacy of Socio-Economic Rights as Human Rights.<sup>12</sup> This has significantly contributed to the lack of will by some states in adopting the Covenant and ultimately domesticating them in their constitution and national laws and the subsequent reliance on progressive realization guising the unwillingness of states to fully realize the right to RH care and the checks and balances that come with this realization. Some of the countries aside from Kenya that have constitutionalized socio-economic rights include; Brazil, Ecuador, Argentina, Colombia, Hungary and South Africa, Brazil seemingly falls in the same category as Kenya,

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<sup>6</sup> Federation of Women Lawyers – Kenya, ‘ Press statement on the increasing troubling trend of Maternal Deaths in Kenya’ (FIDA – Kenya, 20 January 2014 ) < <http://fidakenya.org/wp-content/uploads/2014/02/PRESS-STATEMENT-ON-THE-INCREASING-TROUBLING-TREND-OF-MATERNAL-DEATHS-IN-KENYA-FINAL-1.pdf>> accessed 7<sup>th</sup> December 2017

<sup>7</sup> Constitution of Kenya 2010, Article 43 (1) (a)

<sup>8</sup> International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force on 3 January 1976) UNGA Res 2200A (XXI) art. 12

<sup>9</sup> Jyoti S.S, ‘*Creating a new consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women’s Empowerment*, 2<sup>nd</sup> ed (2012) 33

<sup>10</sup> World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems (Report the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Doc. A/CONF.171/13/Rev. 1(1994).) 11

<sup>11</sup> Ibid (n6)

<sup>12</sup> Ibid (n9) 33

where austerity measures on social policies on health, education amongst other key areas threaten to regress progress made by the constitutionalisation of the right to health as far back as twenty years.<sup>13</sup>

Subsequently, implementation continues to be a grey area at domestic level and in Kenya's case it is pertinent to interrogate the effect of realization of the right to RH care.

### **1.1 Statement of Problem**

Despite the right to health in Kenya, and quite specifically the right to RH Care, being provided for in the Bill of Rights<sup>14</sup> its implementation has been marred with uncertainty and a lack of strategy towards achieving its realization.

Implementation has led to adverse implications for women's sexual and RH and rights and the deterioration of provision of RH services. This situation is characterised by the persevering high Maternal Mortality and Morbidity Rate (MMR) due to a number of complications, including haemorrhage, obstructed labour and unsafe abortions, recorded through the provision of maternal services across the country.<sup>15</sup>

### **1.2 Justification of the study**

This study will help readers understand that the implementation of the right to health and that of the therein reitarated right to RH care in Kenya, might lead to discrimination against women and girls. The legal and policy framework is vague in interpretation and lacks a proper monitoring and implementation framework aimed at the realization of RH care being availed every Kenyan indiscriminately.

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<sup>13</sup> Luis Eugenio Portela Fernandes de Souza, 'The right to health in Brazil: A Constitutional guarantee threatened by fiscal austerity' *Journal of Public Health Policy*, Springer Link (2017)

<sup>14</sup> *Ibid* (n5)

<sup>15</sup> Kenya Demographic Health Survey (2014) 257

### **1.3 Statement of Objectives**

This Research Project seeks to achieve five objectives:

1. To interrogate the legal, policy and institutional framework Kenya has in place to realise the right to RH care. This paper will interrogate the emergence and recognition of sexual and RH rights as human rights.
2. To analyse the various international and national laws and policy frameworks in order to identify the hierarchy and importance of women's right to RH care.
3. To outline and examine the effects of implementation of the right to RH care in Kenya.
4. To draw a comparative analysis with other countries that are progressively implementing the right to RH care and have done so successfully and finally it will propose sanctions on probable measures that should be put in place to progressively realize the right to RH care.

### **1.4 Research Questions**

This research project seeks to answer four key questions.

1. What is the origin and history of reproductive rights?
2. How does the legislative and policy framework administer RH care in Kenya?
3. Who is the most affected by the implementation of the right RH care in Kenya?
4. Which lessons and observations can be derived from other jurisdictions that have constitutionalised the right to RH care?
5. What are some of the long term and short term remedies to the current situation on the ground with due regard to the implementation of the right to RH care?



## 1.5 Theoretical Framework

This study will be based on two main theories. The first is Feminist Legal Theory as posited by Martha Fineman centred on liberalism and vulnerability and founded on the equal moral worth of all human beings.<sup>16</sup> Feminist Legal Theory generally states that the law has historically been complacent in the subjugation of women and further posits that the law could be used to accord equality of the sexes when adopted away from patriarchal systems and in consideration of existing vulnerabilities for women across the divide.<sup>17</sup> Fineman's vulnerability approach argues for a more responsible state and egalitarian society. It goes beyond the foundational assertion of human dignity and equality to assert that focus should go beyond discrimination but further on the structures of society and those intended to be established in order to manage common vulnerabilities across society.<sup>18</sup>

Katharine Barlett asserts that it is pertinent to employ feminist methods of research in feminist areas of study because one cannot change existing patriarchal power structures with the same methods used in their creation<sup>19</sup>. Theorists such as Catharine MacKinnon in their work define the place of feminist jurisprudence as that of giving a voice to women.<sup>20</sup> Feminist Theory<sup>21</sup> has long contended that if women cannot be equal citizens then they cannot have reproductive freedom.

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<sup>16</sup> Martha Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' Yale Journal of Law and Feminism 20 (2018) 2

<sup>17</sup> Francis, Leslie and Smith, Patricia, "Feminist Philosophy of Law", *The Stanford Encyclopedia of Philosophy* (Winter 2017 Edition), Edward N. Zalta (ed.) 2017  
<<https://plato.stanford.edu/archives/win2017/entries/feminism-law/>>

<sup>18</sup> Ibid (n15) 2

<sup>19</sup> Katharine Barlett, 'Feminist Legal Methods, (1990) Harvard Law Review 829, 830

<sup>20</sup> Catharine MacKinnon, 'Feminism, Marxism and State: Towards Feminist Jurisprudence' Chicago Journals 635, 638-9

Male dominance is perhaps the most pervasive and tenacious system of power in history, but because it is metaphysically perfect. Its point of view is the standard for point of viewlessness, its particularity the meaning of universality. Its force is exercised as consent, its authority as participation, its supremacy as the paradigm of order, its control as the definition of legitimacy. Feminism claims the voice of women's silence, the sexuality of our eroticized desexualisation, the fullness of "lack", the centrality of our marginality and exclusion, the public nature of privacy, the presence of our absence.

<sup>21</sup> There are different types of feminist theories. They include; Radical Feminism, Cultural Feminism, Socialist Feminism and Liberal Feminism.

On the other hand, critics of Feminist Jurisprudence assert that in addressing gender issues, the theory adopts a narrow outlook. Janet Halley proposed taking a break from feminism as a solution in order to be entirely 'for women'.<sup>22</sup> In addition, an emerging position of African Feminists is that the Western founded feminism does not cater to the needs or lived experiences of African women and girls. Feminist legal theory in this study will be used to understand and trace the subjugation of women's rights over time through the law and how feminist jurisprudence is evolving to date to remedy this historical injustice.

The second theory that will inform this study is that of Justice. The concept of justice is applied across political, ethical and legal dimensions<sup>23</sup>. Several theorists who have aligned with this theory albeit in different strains. They include Hans Kelsen, Professor H.L.A Hart, Plato and John Rawls. This research project will however focus on the latter theorist, John Rawls.

The theory of justice has often been considered to be reducible to the conventions that happen to crystallize at particular instances of need.<sup>24</sup> Corrective justice will be featured prominently in this study as it responds to a disturbance in the initial distribution of justice and will be largely scrutinised in constitutional judgements that expound on the ingredients deemed necessary to realise and protect the right to RH care for women.<sup>25</sup> One apparent criticism of the theory of justice is its relativity and susceptibility due to shifting standards of human beings in relation to the law.

However, this does not take away from the fact that Corrective Justice would be best suited to remedy the injustice that continues to plague the realisation of the right to RH care. Aristotle

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<sup>22</sup> Brenda Cossman, 'Gender, Sexuality and Power: Is Feminist Theory Enough?' (2003) *Columbia Journal of Gender and Law* 601, 604

<sup>23</sup> This is because it has borrowed from both Natural Law Theory and Positive Law Theory.

<sup>24</sup> George Fletcher, 'Basic Concepts of Legal Thought' (Oxford University Press 1996) 79

<sup>25</sup> *Ibid* 80

states that the just man or woman not only does justice to others but demands that justice be done to him or her.<sup>26</sup> Consequently, the constitutionalisation of the right to RH care served as a form of distributive justice however, the implications of implementation may require the application of Corrective Justice.

Jane English posits that unless viewed through a feminist lens, the "data" of the experiences of women and femme identifying persons (emphasis is mine) in a chauvinist society, cannot be identified.<sup>27</sup> This feminist perspective is confined within Liberal thought and as such principles of autonomy and quite specifically bodily autonomy can be attributed to this school of thought. Liberal Feminism can be interrogated from two perspectives, the first is the undeniable belief of personal fundamental freedom and from a political freedom perspective, being an active determinant in creating the life one wants to live. The second form of Liberal Feminism is commonly referred to as Classic Feminist Libertarianism which posits the existence of freedom from undue or coercive influence.<sup>28</sup>

Personal autonomy is a core component of Liberal Feminism and in essence states the significance and importance of women enjoying their rights and fundamental freedoms in an enabling environment. Substantively, this includes or should include an in-depth analysis through a feminist lens identifying the different experiences of women and ways in which their autonomy has been interfered with or altogether denied and the various attempts put in place to remedy the situation - such as the law. The aforementioned intrinsically and metaphysically establishes the foundation and eventual transition of the overall feminist thought, founded on

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<sup>26</sup> Ibid 92

<sup>27</sup> Jane English, 'Philosophy', Vol.3, No.4 University of Chicago Press (Summer, 1978) 824

<sup>28</sup> Baehr, Amy R., "Liberal Feminism", *The Stanford Encyclopedia of Philosophy* (Fall 2018 Edition), Edward N. Zalta (ed.), URL = < <https://plato.stanford.edu/archives/fall2018/entries/feminism-liberal/> >.

advocating for equality of the sexes, into what we now know and continue to expound on as sexual and reproductive rights.

These conditions largely transcend three focal areas. The first is being violence free and free from its threat. Violence against women remains a significant tool of oppression and suppressor of liberal thought, expression and living for women across the globe. Author Brison<sup>29</sup> rightly asserts that it infringes the dignity of a woman. Dignity is the foundational principle for human rights which are specific to every human being and their treatment. Dignity is not derogable, it cannot be limited and thus cannot be progressively or regressively realised. The author continues to assert that violence (against women) “...fractures the self and takes from women their sense of self-respect.”<sup>30</sup>

In addition, with the contextual setting provided by Brison<sup>31</sup> it is prudent to include sexual violence as a significant component of VAW. Intrinsically linked to resulting in the aforementioned indignity, disempowering consequences and limiting of women’s existence. Subsequently, the second area is that of the overall feminist thought and movements’ goals – dismantling patriarchy. This being the source of all forms of oppression and inequalities for women. Being free of the limits set by patriarchal, paternalistic and moralistic laws<sup>32</sup> is highlighted as a key catalyst towards realising Liberal Feminism.

Women’s lives should be guided by their own interests and values as autonomous human beings. However, this has not been the case in recent past and as stated was and is the root catalyst for feminist movements and thought. All over the world and throughout centuries, paternalistic and

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<sup>29</sup> Brison S.J, ‘Contentious Freedom: Sex Work and Social Construction’ *Hypnata A Journal of Feminist Philosophy* vol. 21 Issue 4, (2006) 192 - 200

<sup>30</sup> *Ibid* (n2) 824

<sup>31</sup> *Ibid* (n3) 193

<sup>32</sup> *Ibid* 28

patriarchal law quite commonly, through the subtext of morality, established by society in the best interests of the general society and quite specifically that of women. A key example can be observed in the continuous and ever changing fight and advocacy for women to exercise and enjoy rights to access abortion, sex work and freedom to sexual identity and expression.

Paternalism is explored as a key component of interrogating and establishing the extent of justice and quite specifically in realising equality and the presiding cohort of women's rights. There are various scholars who have explored the prevalence of justice and its establishment. This chapter will analyse two, John Rawls on his *Theory of Justice* and *Law of Peoples* and Hans Kelsen's theory of the Grundnorm. Consequently, it shall provide a feminist critique and evaluation of their premises on justice and its relation with society.

In *Theory of Justice*<sup>33</sup> John Rawls establishes the concept of a Social Contract as the intrinsic and complex web that sets the stage for the creation of equality and subsequently justice. Albeit theoretical, John asserts that to ponder about justice is to query what principles it would comprise of and to agree upon them from an initial state of equality. He posits that should we (society) gather to identify principles that would constitute equality, fairness – justice, this act would be referred to as a social contract. He continues to assert that should the persons gathered all exist at that time with no bias or unfair disadvantage or advantage such as economic class, then the principles constituting justice would be in effect from a position of equality and thus result in equality on application.

Rawls further prods and questions what principles we would be able to realize as rational, self-interested persons. Referring to self-interested, Rawls refers to our innate human biases driven

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<sup>33</sup> Michael Sandel, *Justice: What's the Right Thing to do?* (Farrar, Straus and Giroux 2009) 141

by our values and beliefs. That with the removal of these self-interests no one would suggest principles that might or potentially lead them to a point of disadvantage if ever they were caught in a certain circumstance. Certainly, he posits that no one would choose utilitarianism which asserts that the morally right action produces the most 'right' or the most good. Rawls explains this assertion with an example; Behind the veil of ignorance each person is not identifying with utilitarianism would think, "for all I know I might end up being a member of an oppressed minority." Nor would anyone select a purely laissez faire libertarian approach as we would not want a situation where we would give people the right to purely and entirely monopolise markets or own them. In this regard he posits the principle of Justice as Fairness.<sup>34</sup> The veil of ignorance allows for a fair discussion on the principles of justice with due regard to structure of a liberal civilization.<sup>35</sup>

Put simply, we would all want to preserve our interests internally and externally and that would require a concession that would ensure equality leading to justice in any eventuality that threatens our individuality. Author Sandel describes the thought process as one of unsurety occasioned by approaching the social contract from an unbiased point of view. He posits that one would envisage the result of them being themselves, as a result of this thought process, as being - "the next Bill Gates" and at the same time realise that they might end up on the other side and temper down their approach possibly thinking - "I might end up being a homeless person so I would rather avoid a situation that could leave me destitute and without help...".

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<sup>34</sup> Ibid 142

<sup>35</sup> Eileen Hunt Botting, 'Rawls on International Justice in Feminist Interpretations of John Rawls', Ruth Abbey ed., (Penn State Press 2013) 4

Subsequently, it is pertinent to interrogate the expected outcome from the use of this approach with due regard to dismantling patriarchy and paternalistic laws and thus seek to establish how this social contract would look like for the realization of the right to RH care.

Rawls believes that two principles of justice emanate from the aforementioned thought process the epicentre of which is the social contract. The first would provide equal and basic liberties for all citizenry - Civil and Political Rights – predominantly nothing too contentious. This principle would take precedence over aspects of social utility and general welfare. The second principle pertains social and economic equality (the crux of the question this paper seeks to answer). The principle does not require equal distribution of income and wealth it permits only those socio - economic inequalities that work to the advantage of the least well-off members of society.<sup>36</sup>

Rawls arguments on International Justice, were further expounded, refined and even redesigned in his 1993 publication *Law of Peoples* commonly referred to as *LP* (and hereinafter). In *LP*, Rawls asserts that a Law of Peoples comprise a set of norms and practices geared towards governing a liberalised and just people domestically and internationally. He refers to these principles as a structured utopia consisting of a society of peoples that make up a cooperative, peaceful and international community hence in *LP*, Rawls alludes to International Justice.<sup>37</sup>

Rawls asserts that this society of peoples exists even in the instance where the society is not filled with people who are liberal and justice centered or cannot conform to it. It works as an ideal for behavioral guidance of both liberal and non-liberal people.<sup>38</sup>

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<sup>36</sup> Ibid

<sup>37</sup> Gary Chartier, 'Peoples or Persons? Revising Rawls on Global Justice', *Boston College International and Comparative Law Rev.* 1 (2004) 2

<sup>38</sup> Ibid (n41) 3

## **1.6 Research Methodology**

The research in this study is qualitative and shall be informed by doctrinal research methodology. a combination of other relevant and pertinent research methods. The area of focus of this study is largely founded on contextualising the existence or lack thereof of discrimination being experienced by women despite there being laws advocating for the opposite. Doctrinal methodology is pertinent because without an understanding founded on legal study and analysis from a feminist perspective, claims founded on feminist legal thought or jurisprudence would thus be considered flawed.<sup>39</sup>

It is pertinent to note that empirical evidence and feminist legal methods have been, and continue, to be used to reveal the law's neglect of women's RH and legal bias that damages women – largely through implementation.<sup>40</sup> Also demonstrated, is the governmental neglect of RH care, the world over, resulting in documented high levels of avoidable maternal and infant death and sickness and the ripple effect of excluding women from educational, economic and social opportunities.<sup>41</sup>

## **1.7 Literature Review**

SRHR are among the most profound and controversial rights in the human rights discourse in Kenya and globally. This is largely due to the fact that they, for the most part, relate to women and girls due to the various injustices meted out on women because of their gender. When compounded with the history of subduing of women experienced across the world, their effective implementation or lack thereof becomes more complex. An analysis of the literature available on the implications of the progressive implementation of the right to RH care, reveals a gap in

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<sup>39</sup> Ibid (n11) 831

<sup>40</sup> Rebecca Cook, 'International Human Rights and Women's Reproductive Health', (1993) *Studies in Family Planning*, vol.24, No.2 75 <http://www.jstor.org/stable/2939201> accessed on 20th July 2018.

<sup>41</sup> Ibid



literature highlighting the discriminatory result due to inadequate measures to check the progressive implementation process. The absence of this pertinent information informs this study.

**Mbazira**<sup>42</sup> in the Chapter **The Judicial Enforcement of the Right to the Highest Attainable Standard of Health under the Constitution of Kenya** emphasizes on an important aspect in understanding the scope and effective applicability of the right to health. The right to health is generally not to be understood as the right to be healthy. It is compounded by various other freedoms and entitlements.<sup>43</sup>

The author also highlights the state of RH care in Kenya and notes that there is an increased lack of availability of family planning services and information, abuse and neglect during delivery, discrimination and detention in health facilities for inability to pay.<sup>44</sup> However, the author fails to further interrogate as to why these implications are experienced in the provision of RH care.

The lack of deliverables and timelines in the RH care policy framework is seen in the **Kenya Health Policy 2014 -2030**. The Policy document though listing down various strategies in implementing the right to health fails to clearly provide measures to ensure the realization of the right to RH care for the duration of applicability of the Policy Framework.<sup>45</sup>

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<sup>42</sup> Christopher Mbazira, 'The Judicial Enforcement of the Right to the Highest Attainable Standard of Health Under the Constitution of Kenya', in Japhet Beigon and Godfrey M. Musila (eds) *Judicial Enforcement of Socio-Economic Rights Under the New Constitution: Challenges and Opportunities for Kenya* (Judiciary Watch Report Series by the Kenyan Section of the International Commission of Jurists) Vol. 10 (2011)

<sup>43</sup> CESCR, *The Right to the Highest Attainable Standard of Health* (General Comment No. 4, 2000) para 3  
These include sexual and reproductive freedom, right to be free from interference, right to be free from torture, non-consensual medical treatment and experimentation.

The Committee mentions the other socio-economic rights that include food, housing, water, work, education, human dignity, life, non-discrimination, equality, the prohibition of torture, privacy, access to information, and freedoms such as association, assemble and movement.

<sup>44</sup> Center for Reproductive Health Right, *Health Rights Failure to deliver: Violation of Women's Human Rights in Kenyan Health Facilities* (2007)

<sup>45</sup> Kenya Health Policy 2014 -2030 Chapter 5, 55

**The KNCHR Inquiry Report**<sup>46</sup> highlights the policy framework on SRHR. It states that realizing the right to health in its entirety is part of the country's long term development blueprint. However, during the strategy's existence it is expected that the state of RH care should have improved but in practice, this is not the case on the ground. The report from the findings of the inquiry affirms that the legal and policy framework for RH care exists but the lack of efficient implementation mechanisms hinders accessibility to majority of Kenyan women.

**Orago** in the chapter **A Gender Perspective of Socio-Economic Rights under the 2010 Constitution of Kenya: A Mirage or a Path towards Women Empowerment**' in **Judicial Enforcement of Socio-Economic Rights Under the New Constitution: Challenges and Opportunities for Kenya**<sup>47</sup> highlights the importance of fully realizing socio-economic rights in a bid to establish women's empowerment and increase the nation's productivity in general. He refers to the lack of full realization and implementation of socio-economic rights for women as the feminization of poverty. He asserts that intra-household inequality, biases against females and the implementation of neoliberal economic and structural adjustment policies as the beginning of a cycle of inequality for women. Citing various social indicators as outcomes he gives the example of education. Although the percentage of girls and boys attending school in Kenya are almost equal, there is a higher death rate for women of child bearing age, including adolescent girls. This is related to issues of child bearing and lack of access to adequate RH care and the lack of control over their sexuality leading to unplanned childbearing. The author albeit acknowledging the discrimination against women in implementing the right to RH care, fails to

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<sup>46</sup> The Kenya National Commission on Human Rights, *'Realising Sexual and Reproductive Health Rights in Kenya: A Myth or a Reality?'* A Report of the Public Inquiry into violations of Sexual and Reproductive Health Rights in Kenya (2012)

<sup>47</sup> Nicholas Orago, 'A Gender Perspective of Socio-Economic Rights under the 2010 Constitution of Kenya: A Mirage or a Path towards Women Empowerment?' Japheth Biegon and Godfrey Musila (eds) *Judicial Enforcement of Socio-Economic Rights Under the New Constitution: Challenges and Opportunities for Kenya* (Judiciary Watch Report Series by the Kenyan Section of the International Commission of Jurists) Vol. 10 (2011) 275

acknowledge that the approach adopted by the state is problematic and the lack of timelines for various goals might lead to a lack of clarity that further fuels this discrimination.

**Jyoti Shankar Singh** highlights the importance of understanding RH care beyond maternal mortality. Various aspects are represented under RH care. They include; maternal morbidity, abortion, sterility, contraceptive use, childlessness and family planning<sup>48</sup>. The author provides an in depth analysis of international instruments that inform the recognition and realization of the right to RH care – lessons that can inform Kenya’s realisation process in line with specific timelines and monitoring strategies.

## **1.8 Limitations**

One of this study’s unresolved limitations is its specific focus on the right to RH care which in itself encompasses a wide selection of RH care services directly related to women and girls. Recommendations thus fundamentally (but not in their entirety) touch on women’s rights and welfare. States have the responsibility to enact laws that protect and promote the rights of all persons including vulnerable person such as women and children. Due to the history of discrimination against women in Kenya, the Constitution requires the state to take appropriate measures, as espoused under Article 21(4) of the CoK, to address and offer redress for disadvantages suffered by individuals or groups occasioned by past discrimination. These groups include women.<sup>49</sup>

Another limitation to the study is that the majority of material gathered are international legal and policy instruments. Adaptation of the recommendations informed by these instruments may

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<sup>48</sup> Ibid (n9) 33

<sup>49</sup> James Makau, ‘Role of Judges in Realizing States’ Responsibility to End Violence Against Women: Perspectives from C.K & Others v. Commissioner of Police & Others, Meru Petition 8 of [2012], <<http://kenyalaw.org/kenyalawblog/role-of-judges-to-eliminate-violence-against-women/>> (2014)

not necessarily work effectively in the Kenyan context without domesticating them to fit the varying but very real socio-cultural influences and practices in the country.

## **1.9 Hypothesis**

This study relies on three hypotheses. They include:

1. The entrenchment and constitutionalisation of the right to RH care has given it legitimacy and justiciability.
2. That although Kenyan courts continue to recognize the standing of the right to health, they continue to employ the state's current implementation principle when adjudicating over matters.
3. The lack of a monitoring strategy to check the implementation of the right to health by the duty bearers, manifests as discrimination against women and that if a monitoring strategy is put in place it would highlight and eliminate this discrimination.

## **1.10 Chapter Breakdown**

Chapter one introduces the study topic and what the research shall entail and cover. This shall include a background to the research topic, statement of the problem it has identified, the objectives of the study, the methodology to be employed, limitations present and hypotheses used.

Chapter two shall trace the evolution of RH rights and how they are manifested in the Kenyan context through the analysis of two key constitutional petition decisions where the courts have substantively highlighted and interpreted these laws to give interpretation on the implementation of the right to RH care.

Chapter three will contextualize the state of RH care in Kenya and subsequently highlight three areas of reproductive services guided in the first part by the aforementioned Constitutional Petitions and in the second by the contestations and lack of consensus<sup>50</sup> on two of the areas – all are comprehensively encompassed as RH care services. Subsequently, the chapter will identify the implications of implementation of the right to RH care in Kenya in these areas.

Chapter four will feature an analysis and highlighting of lessons that can be learned from jurisdictions that have constitutionalised the right to RH care in their Constitutions and are progressively implementing this right and its various components. The chapter will focus on South Africa and Ecuador as countries representative of two developing continents within which the right to RH has been constitutionalised and where certain aspects of RH care have not been realised.

Lastly, Chapter five will give a summary of the findings, conclusion and recommendations derived from it.

## **1.11 Conclusion**

The study will provide an in-depth analysis into the current implementation of the right to health and right to RH care post the 2010 Constitution of Kenya and seek to identify if its implementation is discriminatory against women. This research will be crucial in the continued application and review of relevant laws and policies that deal with the right to health and quite specifically the right to RH care.

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<sup>50</sup> Oppression and Opportunity: A Study on SRHR and Shrinking Space, Swedish Association for Sexuality Education (2019) 14

## CHAPTER TWO

### TRACING THE ADVANCEMENT OF THE RIGHT TO REPRODUCTIVE HEALTHCARE AND ITS IMPLEMENTATION IN THE KENYAN CONTEXT

#### 2.1 SECTION ONE

##### 2.1.1 Introduction

This chapter commences with a brief feminist analysis on liberal thought and its nuances towards women's rights, equality and bodily autonomy contrasted to the right to RH care. This section shall reinforce the jurisprudential discourse from the theoretical framework in the first chapter with the aim of contextualizing the right to RH care in the general feminist thought on reproductive rights. This shall then be followed by an overview of the advancement of SRHR and their subsequent anchorage in human rights law and practices. It is pertinent to determine this evolution in a bid to ascertain the trends in realisation of the right to RH care in Kenya and the jurisdictions that this research project has included in a bid to identify lessons that Kenya can borrow.

Author Lucia Pizzarossa posits that the advancement of SRHR in its very essence and content has not been received without, fallacies, propaganda or resistance. She further asserts that the evolution of SRHR is a process fraught with confusion and persistent shifts in approach and ideologies. Her observations envisage a divide or lack of uniformity in the approach towards defining and implementing SRHR.<sup>51</sup>

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<sup>51</sup> Lucia Pizzarossa, 'Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law' MDPI (2018) 1

The second section of this chapter shall provide a contextual analysis of the Kenyan scenario with due regard to the implementation of the right to RH care post its constitutionalisation. It will include an overview of the international laws that are applicable to Kenya including guidance fielded at the international level with due regard to the ongoing implementation of the right to health and RH care. Subsequently, this will be followed by an in depth analysis of two constitutional petitions relevant to SRHR broadly and the right to RH care. Each of these cases in their analysis, will provide a lens to identify the laws and principles the Constitutional Division adopted in both judgements and how they fit into the overall realization of the right to RH care.

### **2.1.2 A Feminist Analysis**

Rawls' depiction and leaning towards the tolerating of a liberal approach towards establishing the principles of justice at a national and international level makes his human rights approach quite appropriate and conducive to defending women's human rights in more often than not, instances of cultural and religious conflict and interference.<sup>52</sup> If, for the sake of argument Rawls' two principles are accurate the principles that should emerge would be chosen from an initial position of equality and through the 'veil of ignorance'.

Liberal Feminism has created an environment, as has modern liberalism, where women are able to (or at least expected or intended to) make choices precisely because they are human beings with inherent dignity and thus have the capacity to make the right decision(s) for themselves.<sup>53</sup> Thus the concept of autonomy speaks in its entirety to the inherent fundamental freedoms and rights in every person by virtue of their humanity. As has been the case, in developing nations this has not been idyllically achieved. The concept of autonomy is considered

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<sup>52</sup> Ibid 3

<sup>53</sup> Kara Granzow, 'Deconstructing Choice: The Social Imperative and Women's use of the Birth Control Pill', Culture, Health and Sexuality Vol.9, No.1 (2007) 2 < [www.tandfonline.com](http://www.tandfonline.com) >

as unrealised or is controlled in the instance of women and girls exercising their bodily autonomy and consequent SRHR.

Author Kara Graznow highlights that this can be traced to earlier societal nuances around the lack of mention or reference to a woman as an individual. In the writings of Socrates, Plato and Aristotle there are great and many references to the separation of the mind, body and soul. These notions were carried forward and paternalistically skewed to classify women as inherently animalistic and less individualistic and human due to the reproductive process. Canadian Sociologist Mary O'Brien attributes this sudden change due to the power associated with the role of the woman in reproduction and the man's insecure and rather paternalistic role.<sup>54</sup>

This paternalistic mentality skews Rawls' approach towards Justice and fairness as emphasised earlier. However, anticipating this Rawls' expounds on how an unequal and 'burdened' society depicting the aforementioned situation can be used to realise and protect the human rights and general welfare of women. By virtue of physical processes of reproduction; menstruation, pregnancy and menopause, women were classified as natural and animalistic and less individual – less human.<sup>55</sup> The argument prevailing that women were incapable of rational thought due to their significant role in reproductive roles thereby reducing their personhood and agency of choice significantly.<sup>56</sup>

With this knowledge one clearly contextualises the fight for personal autonomy as a core component of Liberal Feminists. In addition, it vividly paints a picture of the theoretical injustice attributed to modern day human rights violations against women such as early and coerced marriages, female genital mutilation/cutting, beading, unsafe abortions, sexual and gender-based

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<sup>54</sup> Ibid 3

<sup>55</sup> Ibid (n54) 3

<sup>56</sup> Ibid



violence, detention of women in inhumane conditions post-delivery, period shaming, surrogacy just to name but a few.<sup>57</sup>

Rawls asserts that burdened societies will do well to take note of and address women's rights issues and their general welfare. He derives this assertion from Amartya Sen's *Development as a Freedom*, to posit that a society which addresses and realises women's human rights in turn grows politically and economically. He cites the examples of the One Child Policy and preference for boys in China that resulted in mass infanticides, forced abortions, forced children migrations and adoptions. China in a bid to control its population and consequent economic control failed and led to gross human rights violations. However, India took a different approach. The example highlighted by both Amartya and Rawls is that of the Indian state of Kerala where the state deliberately empowered women and made them aware of their civil and political rights. Consequently, most women were able to vote, make informed choices on their day to day living and this resulted in the reduction of population due to increased reproductive control.

Subsequently, we may have a society emerge laden with equal principles to which they would refer to and protect women's rights in general and the right to RH care quite specifically.

### **2.1.3 Tracing the evolution of Reproductive Rights**

SRHR are increasingly gaining traction in the Human Rights space. They have been constitutionalized in many jurisdictions albeit at different intervals. It is pertinent to trace these points of emergence and convergence.<sup>58</sup> An overview of this evolution would best be traced through an analysis and understanding of the content of the ICPD Conferences from 1954 to the monumental 1994 Conference where commitments and compromises led to consensus on the

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<sup>57</sup> Ibid (n11) 8

<sup>58</sup> Ibid (n50) 2

definition of reproductive rights. Thereafter, it is pertinent to highlight the instances where SRHR were integrated into human rights instruments - the instance where the human rights based approach began to be employed and therefore began its association with SRHR that has resulted in the current trends across the globe.

Thus, herein we will trace and identify the aforementioned evolution of SRHR in a bid to understand the foundation and inclusion of SRHR in the Human Rights domain. In addition, it will prove useful in understanding the division that has resulted in growing opposition on account of moralistic grounds and whether this has interfered with the realization of SRHR and in the context of this research project, the right to RH care. This first section will highlight how population centered discourse shifted to couples' SRHR to individual SRHR.<sup>59</sup>

The definition of Reproductive Rights evolved from population related conversations under the auspices of the World Conferences on Population and World Conferences on Human Rights which were convened consecutively.

The first of the aforementioned conferences was the World Population Conference held in Rome in 1954 where the main agenda was addressing development issues through a demographic lens on population matters. This was closely followed by the 1965 Belgrade Conference on Population that featured alarmist conversations on the growing global population and risk of starvation. The conference proposed the control of population through family planning and reaffirmed the neo-Malthusian principle that provides a linkage between population and poverty. The aforementioned conference was closely followed by the International Conference on Human Rights held in Tehran in 1968. Its key focus was on the role and place of Human Rights in the

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<sup>59</sup> Ibid 1

population discourse and world crisis. It is pertinent to highlight that at this stage the population conversation seized to be one between demographers and population specialists and the focus was extended to include representatives of government.<sup>60</sup>

These key conferences ushered in a new model that combined world population trends and how they relate to human rights. The Bucharest Population Conference thus expanded participation to include state representatives and civil society members in addition to population experts and demographers. conference asserted that the population crisis envisaged in the world was not a cause of underdevelopment but a consequence of it. It further highlighted the issues of scarcity of resources and distribution. This assertion falls well in line with Dr. Orago's assertions on the feminization of poverty and the interlinkages between this phenomenon and the right to RH Care in the CoK.<sup>61</sup> Consequently, discourse featured the rights of couples and individuals to decide the number and spacing of children and the significant role of women in population policies and the size of families.<sup>62</sup> In addition, the World Population Plan of Action (WPPA) was launched. It reiterated that states' population policies should be consistent with human rights and should uphold and promote human rights regardless of their overall demographic goals. The wording of the WPPA is indicative of the right to decide freely.<sup>63</sup>

The 1984 Population Conference held in 1984 proved to be quite significant due to the dominant conversations on states' commitments towards providing information, education and means of spacing births which in essence is family planning. In addition, conversations on abortion became controversial to some states and resulted in the Mexico City Policy adopted by the United States of America. It is also popularly referred to as the 'Global Gag Rule'. Essentially

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<sup>60</sup> Ibid 2-3

<sup>61</sup> Ibid (n46) 278

<sup>62</sup> Ibid (n50) 4

<sup>63</sup> Ibid 3

America restricted its foreign aid in terms of restricting the use of these funds for any advocacy or service provision related to abortion. States also emphasised that men are to share full responsibility with women in family planning and child nurturing.<sup>64</sup>

The aforementioned conference was notably followed by the Vienna Conference on Human Rights that emphasised upon the indivisibility of Human Rights. It also highlighted the WPPA and recognized the significance of women's access to physical and mental health. State representatives also affirmed women's rights to comprehensive family planning services.<sup>65</sup>

The ICPD, 1994 set clear benchmarks to measure progress over a period of two decades (1995-2015) towards goals relating to the reduction of infant, child and maternal mortality thus ensuring: the availability of RH services to all those who need them; education, particularly of young girls and women; and the empowerment of women. It also brought forth the critical role of the non-governmental sector in population activities, and firmly established the concept of 'partnership' between states and NGOs. Most importantly, the ICPD provided the first definition of Reproductive Rights that was subsequently adopted by states present. The definition read as follows;<sup>66</sup>

RH is a state of complex physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. RH therefore implies that people are able to have a satisfying

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<sup>64</sup> Ibid 4

<sup>65</sup> Ibid 5

<sup>66</sup> Ibid (n9)34

and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.<sup>67</sup>

The ICPD through the Plan of Action therein adopted highlighted principles that would guide the adoption of HRBA in the realisation of reproductive rights and subsequent development. The principles are founded on the premise that all human beings are born equal and in dignity. Therein the plan of action affirmed the principles of sustainable development and that every person has the right to development. The principles espoused the indicators of equality, the right to development, right to be free from poverty ascertained by economic development, right to access education and information in a bid to realise and enjoy reproductive rights.<sup>68</sup>

The aforementioned evolution provides a clear and concise map on reproductive rights and most especially for this research project, the right to RH care. The aforementioned Plan of Action creates a bedrock to analyse various indicators on the realisation of RH rights and subsequently will guide this research project's contextual analysis on discrimination which is highlighted as any distinction, exclusion or restriction made on the basis of sex thus interfering with recognition of women on an equality threshold across several sectors.<sup>69</sup> Consequently, this leads into the next section that provides context on the Kenyan context on SRHR.

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<sup>67</sup> Ibid 37

<sup>68</sup> Ibid 37

<sup>69</sup> Convention on the Elimination of all forms of Discrimination Against Women, Article 1

## **2.2 SECTION TWO: A CONTEXTUAL ANALYSIS OF REPRODUCTIVE HEALTH RIGHTS IN KENYA**

### **2.2.1 Introduction**

It is pertinent to consider how we can change deeply entrenched norms such as those that drive the discrimination of women and the lack of realisation of human rights. This chapter will commence with a summary description and highlight of laws and policies relevant to realizing and guarding the right to RH care in Kenya. Thereafter it will delve into analyzing these laws through the interpretation of the courts in two landmark constitutional cases relevant to the right to RH care.

The courts have played both proactive and reactive roles when it comes to the law, aimed at protecting and promoting the human rights in relation to women. The courts and quite specifically Constitutional Divisions, have become a powerful tool for social accountability through adjudication fundamental freedoms and rights entrenched in Constitutions. The petitions highlighted herein, though not addressing the right to RH care directly, addressed violations relevant to components of RH including maternal health, SGBV and the right to a safe abortion within the confines of the law. In addition, the Constitutional courts as shall be highlighted reiterate that it is crucial to realise the right to health and RH care for all Kenyans.

### **2.2.1 Legal Framework for Reproductive Health Rights in Kenya**

The universal principle of *pact sunt servanda* is the basis for Kenya's obligations towards the realization of Socio-Economic Rights. It states the duty of a state to oblige to its responsibility under every treaty in force is binding and should be executed in good faith. Consequently, laws applicable in Kenya towards the realization of the right to RH care, may be derived from

international treaties and conventions that Kenya is a party to and from principles that have ascended to the level of general rules of international law. This is affirmed within the CoK under Article 2 (5) and 2 (6).<sup>70</sup>

Kenya anchored the right to health and RH care in general and reproductive in its constitution in 2010. Under Article 43 (1)(a) it states that every person has a right to the highest attainable standard of health including the right to RH care. It further guarantees the protection of women and girls' dignity<sup>71</sup> by asserting the right to equality and non-discrimination<sup>72</sup>, right to Information<sup>73</sup>, right to privacy and confidentiality<sup>74</sup>, right of expression<sup>75</sup> and participation in decision making<sup>76</sup>. This was an approach previously absent in the Independence Constitution.

There exists a gray area as to whether the courts are a suitable driver towards measuring the implementation of Socio-Economic rights. Siri Gloppen and Mindy Roseman assert that often it is argued that courts lack expertise on complex socioeconomic (or medical) issues and that the casuistic nature of court decisions can make it difficult for distributive justice to take precedence when a decision with budgetary implications is being made.<sup>77</sup>

A dismal outlook worth interrogating is also provided by scholar Gerald Rosenberg in his 1991 book, *The Hollow Hope: Can Courts Bring About Social Change?* Where he posits that courts can seldom produce significant social reform.<sup>78</sup>

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<sup>70</sup> Ibid (n29) 282

<sup>71</sup> Ibid (n5) Article 28

<sup>72</sup> Ibid Article 27 Equality and freedom from discrimination

<sup>73</sup> Ibid Article 35 Access to information

<sup>74</sup> Ibid Article 31 Right to Privacy

<sup>75</sup> Ibid Article 33 Freedom of expression

<sup>76</sup> Ibid Article 10 National Values and Principles of Governance

<sup>77</sup> Siri Gloppen and Mindy J. Roseman, 'Introduction: Can Litigation Bring Justice to Health?' in Alicia Ely Yamin and Siri Gloppen (eds) *Litigating Health Rights: Can Courts Bring More Justice to Health?* (HUP 2011) 11

<sup>78</sup> Ibid 12

Whilst, his assertion rings true, various instances based on different country contexts have proved that public interest litigation on health matters can prove a useful and formidable tool for social accountability. However, it is pertinent to note that it is not an absolute tool and is best used as part of larger advocacy measures.

Consequently, given the recent role the Kenyan courts have taken in interpreting Constitutional Rights and quite specifically those contained in the Bill of Rights – this section shall include an analysis of the laws referred to at domestic and international level as guided by the Constitution’s Article 2(5) and (6) that provide for the general rules of international law forming part of the law of Kenya and that any treaty or convention ratified by Kenya shall form part of the law of Kenya under the Constitution. These two provisions reiterate Kenya’s obligations to pertinent conventions and treaties such as the ICESCR, CEDAW, ICCPR, ACPHR, CRC, CAT, ICERD and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families amongst others.

Thus, it is crucial to analyse the laws and policies relevant to Kenya with due regard to realizing the right to RH care at the stage of interpretation or lack thereof.

The right to RH as a human right is believed to have significantly been defined during the ICPD in 1994. Subsequently, the definition given to RH was stated during the conference.<sup>79</sup> The ICPD definition of Reproductive Rights moved beyond the confines of sexual and reproductive control for demographic control and set an expansive phase that defined SRHR as a forged link between sexuality and reproduction free from any form of discrimination or restriction.<sup>80</sup> This marked the

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<sup>79</sup> ICPD Reproductive Health Definition

<sup>80</sup> Lucia B.P and Katrina Perehudoff, *Global Survey of National Constitutions: Mapping Constitutional Commitments to Sexual and Reproductive Health and Rights*, Health and Human Rights, Vol. 19, No. 2, Special Sections: *Romani People and the Right to Health HIV and Human Rights*, The President and Fellows of Harvard



emergence of countless variations developed under various contexts. The conference broke quite a number of barriers with regard to RHR. However, it is pertinent to note that it was held under the already conducted auspices of two other United Nations population conferences, namely; the Population Conference in Bucharest, Romania, 1974; and the Population Conference in Mexico City, Mexico in 1984.

The ICPD Programme of Action<sup>81</sup> also enshrines RH care in its principles which is intrinsically aligned to the definition of the right to health provided by the CESCR under General Comment no. 14 para 1 that states;

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.<sup>82</sup>

Prior and parallel to this, Reproductive Rights were generally attributed to safe motherhood, child health and FP. Although the latter is acknowledged as a cornerstone of public health and the conceptualisation of RH , some scholars argue that its classification as a part of RH and subsequently Reproductive Rights is mistaken.

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College on behalf of Harvard School of Public Health/François-Xavier Bagnoud Center for Health and Human Rights (December 2017) 279-293

<sup>81</sup> ICPD Programme of Action, 1995

<sup>82</sup> CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)

However, it would be folly to look at one without the other. Maternal Health and in essence safe motherhood are a significant component of RH Care and have formed the foundation for the expanded discourse that has led to various definitions of RH Care.<sup>83</sup> With due regard to the Kenyan RH Care Situation this research paper shall highlight and analyse two cases that address gaps in the area of maternal health care services, SGBV in relation to access to safe abortion within the Constitutional parameters.

### **2.3.1 MAO and Another v. Attorney General & 4 Others [2015] eKLR (*Maimuna Case*)**

On Madaraka day, June 1, 2013 President Uhuru Kenyatta declared maternal healthcare free across the country.<sup>84</sup> This was deemed a response to the ongoing challenges in the County and National health facilities with due regard to provision of comprehensive, affordable and quality maternal care to women and girls as part of their right to RH care as provided for in the Constitution 2010, Article 43 (1)(a).

#### **2.3.1.1 Summary of Facts**

The first petitioner MAO was a woman living positively with HIV and a mother of six. She was a casual labourer and earned, on a good day, Ksh. 300 with daily expenses as highlighted in court of up to Ksh. 200. On 20<sup>th</sup> September 2010, MAO went to a clinic in Eastleigh to seek maternal care and specifically delivery of her pregnancy. This facility was her first option due to the subsidised fees she knew would be applicable and did not intend to spend more than Ksh. 1,000.

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<sup>83</sup> Wallace, M. Ellen et al, 'The Status of Women's Reproductive Rights and Birth Outcomes', Women's Health Issues Journal Issue 27-2 (2017) 121

<sup>84</sup> Maternal Health Care free, President Kenyatta announces < <https://www.nation.co.ke/news/Govt-rolls-out-free-maternal-care/1056-1869284-11xiis8z/index.html> > accessed on September 17, 2019

There were complications however, and her child was declared to be in breech position<sup>85</sup> and as such was referred to Pumwani Maternity Hospital, a higher level facility. On arrival, she was asked to pay Ksh. 3600 and purchase a cup, plate and cotton wool which she diligently did but to her consternation these same items she bought were billed to her at discharge. She did not have any complications and was discharged the day after giving birth, she was however incapable of paying the required Ksh. 3600 and sought assistance from the hospital's social worker and hospital matron in vain. Consequently, she was detained at the hospital from 21<sup>st</sup> September 2010 and 15<sup>th</sup> October 2010.

During her detainment she stated that she suffered trauma from mistreatment by the nurses, with other detained patients they had to share beds and in some instances mothers would have to sleep on the floor in order to allow their newborns to sleep on the bed. MAO also asserted that the room they slept in was located next to a toilet that would flood, they did not have adequate blankets to shield them from the cold and did not receive any medical check-up even though they had just delivered. Subsequently, she was released through a mercy act by then mayor of Nairobi, Geoffrey Majiwa, to detained women post-delivery. Thereafter, MAO realised she had contracted pneumonia as a direct result of the deplorable conditions during detention.

The second petitioner told the court that her first stint with detention post-delivery was when she was 15 years old in 1991 where she underwent a C section. On discharge, being a minor she was unable to pay the hospital fees and was detained for 7 days. As a result, she was scarcely fed even though she had just undergone a surgical procedure. Subsequently, her 'husband' raised the money and she was eventually discharged. However, she experienced pains and discomfort in

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<sup>85</sup>Fetal Presentation before birth < <https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/multimedia/fetal-positions/sls-20076615?s=5> > accessed on September 17, 2019

her lower abdomen and was taken back to Pumwani Maternity Hospital where it emerged that a pair of surgical scissors had been left behind during the caesarean section. The situation was remedied.

In November 2010, the second petitioner experienced government owned and run Pumwani Maternity Hospital once more. She was pregnant and had opted for a City Council run clinic for her delivery due to the subsidised costs of delivery. On her way there for an antenatal clinic she started bleeding. Her sister managed to hail a taxi and they headed to Pumwani Hospital. On arrival, the hospital was quite crowded and the nurses asked the taxi driver and second petitioner's sister to place her on the floor. She was still bleeding. As she sat on the floor at the reception area, a female doctor happened to pass by and realised she was about to deliver in breech position and could consequently die. She ordered immediate surgery two hours after her arrival as an emergency case. Thereafter, the petitioner underwent systemic abuse from the nurses who eventually realised the second petitioner was heavily bleeding. The doctor diagnosed a ruptured bladder and took her back to surgery for a catheter. Her bladder ruptured due to the neglect of the nurses who failed to attend to the second petitioner when she requested for assistance to go to the toilet. On completion of this second surgery, the second petitioner realised that her stitches were infected and badly done. She was discharged five days later but could not pay the required amount even though she offered to offset a half of the Ksh. 12,300 bill. She fell back into the cycle of mistreatment of detained patients where they were scarcely fed, slept on the floor and were not allowed to go out into the open – essentially detained. Eventually she was released after her relatives raised and offset her bill. The respondents in the petition, including the hospital, denied that the detention had taken place.

### 2.3.1.2 Analysis

The decision in the Maimuna case by the court set the context and foundation for a comprehensive analysis of the implementation of the Right to RH care as provided for in the Constitution of Kenya as part and parcel of the Right to Health.<sup>86</sup> Even though the violation asserted was detention which resulted in other human rights violations including the right to RH Care, the court's holistic interpretation proved a milestone in terms of understanding the significance of the right to RH care and its indivisibility to human rights. In addition, the case sought the interpretation of emergency treatment as enshrined under Article 43 (2) of the Constitution<sup>87</sup>. Most evident from the court's judgement and interpretation was that of international human rights laws relevant and applicable to the Kenyan Context.

The court held that the petitioners' detention due to their inability to pay was arbitrary, unlawful and unconstitutional. With due regard to the detention the court stated and referred to Article 29 of the Constitution that guarantees the freedom and security of the person which entails the right not to be deprived of freedom arbitrarily or without just cause or detained without trial. The court also emphasised on the provisions of Article 39 that enshrine the right to freedom of movement. The court also invoked Kenya's international human rights obligations as guided by the Constitution's Article 2(5) and (6) as I had highlighted earlier. It highlighted Article 9(1) that provides for every person's right to liberty and security of person and that no one shall be deprived of his liberty except on such grounds and in accordance with procedures established by law. The bench leaned towards General Comment no. 35 of the United Nations Human Rights Committee which indicates states obligations under the ICCPR (which Kenya has signed, ratified and domesticated as law through the Constitution) to protect persons against violations of the

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<sup>86</sup> Ibid (n5) Article 43 (1)(a)

<sup>87</sup> Ibid Article 43 (2)

right to liberty by third parties including lawful organisations such as schools, hospitals and even employers.<sup>88</sup> The court also asserted the intrinsic link between arbitrary arrests and other fundamental freedoms and rights. It referred to the case of Beatrice Wanjiku & Another (*supra*) where the court outlined implications on other rights as a direct result of arbitrary arrests. It stated verbatim,

“...Committal and imprisonment constitutes a violation of fundamental rights and freedoms guaranteed by our Constitution. The right to inherent dignity of the person protected under Article 28 is a proclamation of our humanity. Arbitrary arrest and imprisonment degrades the human spirit, affects families and relationships. Arbitrary arrest and committal also infringes the right to security of the person protected under Article 29, the right to a fair trial protected under Article 50(1) and the right to movement under Article 39. A consideration of all these rights points to the fact that arrest and committal of a judgment-debtor constitutes a violation of the collectivity of these rights.”<sup>89</sup>

On review of a number of decisions in the Kenyan and South African jurisdiction, the court was convinced that there was no justification for any institution legal or not, to arbitrarily hold a person for non-payment of a Bill.

The court emphasised that the right to health and the right to dignity are inextricably linked and that healthcare institutions should be in a position to be held accountable to provide health care services that respect and uphold human dignity. The court also referred to a case in the Inter

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<sup>88</sup> Millicent Awuor Omuya alias Maimuna Awuor & Another v. The Attorney General & 4 Others (2015), Petition No. 562 of 2012 Kenya, High Court, Constitutional and Human Rights Division, <eKLR> accessed on September 16, 2019

<sup>89</sup> Beatrice Wanjiku & another vs Attorney General & Another [2012] eKLR

American Court of Human Rights where it was held that the denial of essential RH services to a woman caused mental suffering amounting to ill treatment. This decision was also relied on by the European Court of Human Rights in *RR v. Poland* [2011] No. 27617/04 which echoed the same finding as the Inter American Court of Human Rights.<sup>90</sup> It is pertinent to note that both these cases did not only find violations with due regard to RH rights but also went further to state the significant and undeniable role the state has to play in the realisation and protection of the right to RH care.

The court in emphasising the Right to Health as provided in the Constitution of Kenya gave a comparator with the provisions of the ACPHR under Article 16<sup>91</sup> and Article 12 (1) of the ICESCR<sup>92</sup>.

The Court stated that the right to health is indispensable to the enjoyment of other rights and as such encompasses a positive obligation to ensure that services are provided and the negative duty not to do anything that in itself would affect access to in general, health care services and quite specifically RH services.

Under para 146 the court further touched on the nature of realization of the right to health and RH care as provided for in the CoK and guided by the CESCR General Comment no.14 on the right to health which in part provides that the state shall ensure the right to access health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups. The court also affirmed that the petitioners in the case in addition to the

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<sup>90</sup> *Miguel Castro-Castro Prison v. Peru*, ((2006) ser. C, No. 160) and also *RR v. Poland*, ((2011) No. 27617/04) < [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_181\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_181_ing.pdf) > accessed on September 17, 2019

<sup>91</sup> African (Banjul) Charter on Human and Peoples' Rights, Article 16

<sup>92</sup> *Ibid* (n7)

failure of the state to ensure they enjoyed their right to health and RH care, were additionally discriminated against. The court asserted that there was a disproportionate impact on poor women's ability to access health care which negated their ability to enjoy their constitutional rights and fundamental freedoms. The consequences of the pervasive discrimination hinder their accessibility to maternal health services in turn infringing their right to the highest attainable standard of health and RH care.<sup>93</sup>

The significance of this judgement towards the realisation of the Right to RH care is twofold. Firstly, it attempts to remedy the violations suffered by the petitioners and secondly it gives a comprehensive breakdown of the applicable laws, both international and national, that provide for the realisation of the right to RH care. It is quite a comprehensive judgement in addressing the rights that are violated when health systems deny maternal health services or treat them badly and deny them their right to RH care if they cannot or do not have the resources to pay for these services. A key lesson emanating from the discourse is that in the Kenyan context, whilst maternity is a celebrated phase of life for women, it is a dangerous affair for them with due regard to receiving health services let alone quality services as prescribed through the AAAQ (Availability, Accessibility, Acceptability and Quality) Framework on Health.

Secondly, it reaffirms the guidance provided by the CESCR on the implementation of the right to health and in Kenya's case, this is inclusive of the right to RH care as provided for under article 43(1)(a). The court highlighted that the principles of progressive realization are provided for under Article 20(5) of the CoK and that the onus is on the state to show that resources are not available to implement the right to health and RH care, that it should also give priority in ensuring the widest possible enjoyment of these two rights in the allocation of resources and with

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<sup>93</sup> Ibid (n90) para 190



particular focus on marginalized and vulnerable groups. The court also highlighted that under the guidance of CESCR, states should ensure reproductive maternal and child health care is realized through the adoption and implementation of a national health public strategy and plan of action to address health issues. The interpretation of the court provides sound guidance on the balance that the state is obligated to realise with due regard to the implementation of the right to health and RH care and even though limited resources necessitate progressive realization a balance should be realized and the former cannot justify violation of Article 43(1)(a) of the CoK

***2.3.2 Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 others; East Africa Centre for Law & Justice & 6 others (Interested Party) & Women’s Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR***

RHC is quite a wide and comprehensive range of services all of which look towards ensuring women are treated with the dignity that is owed to every human being. As highlighted in the Jurisprudential Analysis in the first part of this chapter, one of the key struggles for women all over the world across decades has been the lack of agency and control over their bodies, relevant to this discourse – the right to make reproductive choices over their own bodies. In Kenya, this continues to be the plight of women and girls who, despite the progressive provisions of the Constitution, have no autonomy to exercise their rights and enjoy them.

During the hearing of Petition 266 of 2015 at the Constitutional Division<sup>94</sup>, a case that in its facts alone demonstrated the extent to which the law has the ability and power to ensure a woman or girl attains the highest standard of health or realize the exact opposite of that. The case

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<sup>94</sup> Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 others; East Africa Centre for Law & Justice & 6 others (Interested Party) & Women’s Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR

featured a petitioner ,JMM, who was a minor and who had undergone defilement<sup>95</sup> and as a result became pregnant. This was the commencement of JMM’s story – an ordeal that clearly envisages how a health care system obligated to provide the highest attainable standard of care and realize her right to RH care failed one out of half of the female population in Kenya that has endured maternal mortality and morbidity.

Due to the continued stigma attributed to survivors and victims of Sexual and Gender Based Violence, she did not share the details of the ordeal with anyone. Consequently, she chose to procure an unsafe abortion and as a result suffered severe morbidity. Only then, did JMM’s mother realise her child was unwell. This was the commencement of their tale. They visited four health facilities including; Kisii Teaching and Referral Hospital, Tenwek Mission Hospital, Moi Teaching and Referral Hospital and Kenyatta National Hospital, that were alleged at the time to be ill equipped or unwilling to offer abortion related services (in this case post abortion care services) that have been provided for and allowed through the Constitution of Kenya Article 26(4), 43 (2), the Health Act of Kenya 2017 and Post Abortion Care Guidelines provided by the Ministry of Health. This failure to effectively act was demonstrated by one of the petitioners in the case FIDA Kenya, to be directly linked to a memo issued by the Ministry of Health arbitrarily withdrawing the Standards and Guidelines for the Reduction of Morbidity and Mortality from Unsafe Abortion – at the behest of right wing groups that complained of a lack of consultation and involvement in the process.

Consequently, by the time the main petitioner JMM reached the fourth facility Kenyatta National Hospital, there was considerable damage to her internal organs and she was diagnosed with

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<sup>95</sup> Sexual Offences Act of Kenya No. 3 of 2006 Section 8 Defilement

kidney failure which required immediate dialysis. JMM's mother PKM asserted that she had to sell most of her meagre property to cover the costs of the dialysis. Eventually JMM passed on even before the case reached an end. This year, she would have been eighteen years old, an adult with the opportunity to continue living a full life.

### **2.3.2.1 Analysis**

The five judge bench unanimously held that the withdrawal by the ministry of health was a violation of the right to health and RH care and quite specifically access safe to safe abortions within the parameters of the law. The bench in its judgement asserted that the definition of health should be as provided by the World Health Organisation to mean that, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.<sup>96</sup> This definition of health is also adopted in the Maputo Protocol. The court's adoption of this definition is quite instrumental to interpreting Article 43(1)(a) which encompasses the right of every person to enjoy the highest attainable standards of health including the right to RH care. Within this context the bench sought to elevate the discourse on a basis of equality and not merely an issue specific and unique to women and girls in their reproductive capacity but as human beings entitled to dignity and the highest attainable standards of health care.

One of the interested parties popularly identifying as a conservative professional organisation known as the Catholics Doctor's Association through their chairperson asserted under oath that women and girls who get pregnant through sexual violence (rape and defilement) should not terminate pregnancies even when their lives are in danger and should only seek counselling –

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<sup>96</sup> Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. < <https://www.tandfonline.com/> > accessed on 17 December 2019

victims should then be advised to keep the pregnancy or give up the child for adoption.<sup>97</sup> The interested party in this case happened to be a man and a qualified obstetrician and gynaecologist duly registered under the Catholic Doctors Association, Kenya Medical Association and actively offering RH care services to women and girls. As intimated by the author Kara Granzow, "...the struggle for women's emancipation has been the struggle towards women's inclusion as rational actors in the social and public sphere." The above excerpt from the proceedings is a clear indication of the interference of personal values and beliefs with a woman's dignity and right to RH care – and their agency to choose the range of RH services best suited for them and thus ultimately exercise their right to health.

Thirdly, the court also asserted that the government's actions restricted access to information and created confusion about the grounds for lawful abortion. They asserted that the prevailing confusion led to a reduction of availability of medical and legal abortions and their availability to be administered by trained health professionals who are not medical doctors, such as nurses and midwives, leading to women and girls who are victims of sexual violence or require access to lawful abortion services, being dependent on unsafe abortions, at the hands of quacks.<sup>98</sup>

As depicted in the Maimuna Case herein at 2.3.1, the Court in this instance reiterated its adoption of the definition of health as stated in CESCR General Comment No. 14 on Right to Health in the case of *P.A.O & 2 Others v Attorney General* [2012]<sup>99</sup> as highlighted below;

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<sup>97</sup> Paul Ogemba, "Rape victims should not abort, court told" < <https://www.standardmedia.co.ke/article/2001305066/don-t-allow-rape-victims-to-abort-says-catholic-doctors> > accessed on Sunday, September 8, 2019

<sup>98</sup> Ibid (n75) 129

<sup>99</sup> *P.A.O & 2 Others v Attorney General* [2012] eKLR

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.

Once more the relevance and significance of the bench reiterating the operational aspects of international human rights law in the Kenyan Context (and specific to this paper's content) can be perceived in various ways, key among them; expanding on the definitions of provisions on the right to RH care in the Constitution and through the precedence set by the case create binding law.

The courts, as is envisaged in the two cases above, have become a stage to set a scene to realise rights otherwise held at ransom by the state but also a clear platform to evaluate the various socio-cultural influences that so significantly attempt to impact or interfere with human rights, constitutional rights and in this case contentious aspects related to the right to RH care. Through the dispensation of the Kenyan Constitution the judiciary continues to be empowered with devices that are pertinent in adjudicating public interest litigation cases in whichever manner they are brought forth. Thus far, a majority of decisions have featured comprehensive interpretations of both the Constitution and International Human Rights Law. However, it is important to interrogate the impact of the elaborate laws and progressively fair judiciary on the citizenry and how these high level provisions translate into implementation. That will be the core context and content of the next chapter.

## **Chapter Summary**

Whilst there are few studies that have been conducted to specifically and accurately measure the impact of strategic litigation towards aiding the realization of Socio-Economic rights, some have

posited that the courts' progressive judgements, while not directly resulting in a change of policy, inject a rights based language in otherwise political discussions thus offering an alternative forum for debate. This courts are arguably more inclined to working within a system of checks and balances driven by principles such as fairness and justice.<sup>100</sup> This is evident in the Maimuna Case which was heralded by an executive order for free maternity care nationwide. Additionally, from the analysis of the two cases above, the courts have provided guidance on the laws applicable towards addressing the social injustices brought forward by the petitioners of the case and consequently attempting to remedy the disparities occasioned by these injustices.

Accordingly, it is vital to recognize the role the Kenyan Constitutional and Human Rights Division has played with due regard to giving life to the Constitution's Bill of Rights juxtaposed against International Treaties and Conventions that Kenya has signed and ratified and subsequently form part of Kenyan law. Notably, in the Maimuna case, the court asserted the linkage between the reproductive injustice experienced by the petitioners over time as a systemic violation by the state and an infringement of their right to be free from torture. Baehr in the book *Human Rights: Universality in Practice* posits that aside from physical pain, mental suffering is a key ingredient to establish torture and this violation is used as a means of intimidation and subjugation.<sup>101</sup> This seemingly unveils the next chapter's discourse highlighting the realization of the right to RH care and recorded outcomes.

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<sup>100</sup> Ibid (n57) 11

<sup>101</sup> Peter R. Baehr, *Human Rights: Universality in Practice*, (Palgrave 2001) 23-24

## CHAPTER THREE

### IMPLICATIONS OF THE REALISATION OF THE RIGHT TO HEALTH IN KENYA

#### 3.1 Introduction

This Chapter shall feature an analysis of existing data on three areas of RH care that are deduced from the two Constitutional cases highlighted in the previous chapter. In analyzing various findings through data and statistics Roscoe Pound's arguments and thinking on, '*Law in the Book versus the Law in Action*' can be employed to measure the level of implementation, in this case that of the right to RH care and thus attempt to create a chain of causation that leads to the experiences of women and girls as highlighted in the Maimuna Case<sup>102</sup> and JMM's<sup>103</sup> case in the previous chapter.

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<sup>102</sup> Ibid (n69)

<sup>103</sup> Ibid (n75)

Roscoe Pound in drawing a distinction on the law in action and that which is in the books gave a brief illustration stating that the distinction between different legal theories could be best understood through certain life related illustrations. In one, he gives the example of tools that can be used to achieve a task “... when tradition prescribed case-knives for tasks which pickaxes were better adapted, it seemed better to our forefathers, after a little vain struggle with case-knives, to adhere to principle – but use the pickaxe. They granted that law ought not to change. Changes in law were full of danger. But, on the other hand, it was highly inconvenient to use case-knives. Therefore the law has always fastly demanded a case knife, and to wield it in the virtuous belief that it was using the approved instrument...” at the end of the illustration, after the use of case knives proved futile the two characters adopted the use of a pickaxe which proved more effective.<sup>104</sup>

The aforementioned provides a practical view of what the law in the books provides and that the practicality of it in terms of implementation may vary significantly. Roscoe Pound asserts quite notably and in relation to this paper’s core methodology on analysing the RH Legislative framework, the significant role of the courts in interpreting the laws in relation to social issues and rights. He reiterates the sentiments of Professor Freund emphasising that in practice the courts tend to adjudicate on certain laws and their unconstitutionality on the premise of their wisdom.

In order to understand the impact of implementation on the right to RH care, this chapter will feature an analysis of recent reports and studies highlighting data and statistics relevant to realising the right to RH care and consequently highlighting the progress in the realization of the right to RH care.

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<sup>104</sup> Roscoe Pound, *Law in Books and Law in Action*, (44 American Law Review 12. 1910) 2 -3



### 3.2 The State of Reproductive Health in Kenya

On August 27<sup>th</sup> 2010, Kenya promulgated a new constitution that marked the commencement of what can be considered a reformist era for human rights enshrined within Cap 4 of the CoK under the Bill of Rights. Key among them was the inclusion of Socio-Economic Rights including the Right to Health and the profound distinction of the Right to RH Care. In addition, other fundamental rights and freedoms key to the implementation and realisation of the aforementioned are contained in the Bill of Rights. These include the Right to Access Information, Right to Life, Freedom from Torture and Inhuman treatment, Right to Human Dignity and Equality and Non-Discrimination. These fundamental rights and freedoms have all been highlighted as part and parcel of the implementation and realisation of the right to health and RH care as espoused in the Maimuna Case.<sup>105</sup> It asserts, as guided by the ICPD 1994 adoption on the definition, that an individual or couple can make an informed decision to reproduce and to decide if and when to do it in addition to enjoying a satisfying sex life.<sup>106</sup>

The global challenges that have incorporated components of the right to RH care have included the MDGs (1990 to 2015) and the Sustainable Development Goals (2015 to 2030). MDGs included commitments adopted by all 191 member states of the UN at the time and 22 International Organisations, that committed to help achieve the MDGs. During the United Nations Millennium Summit saw the signing of the United Nations Millennium Declaration. It is pertinent to note that the MDGs were all inter-dependent and all eight influenced health, and health influenced the realisation of all the MDGs.<sup>107</sup> MDG 4 and 5 highlighted the obligation to

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<sup>105</sup> Ibid n64

<sup>106</sup> Sexual and Reproductive Health, <<https://kenya.unfpa.org/en/topics/sexual-reproductive-health-4>> (accessed on October 1, 2019)

<sup>107</sup> Millennium Development Goals <[https://www.who.int/topics/millennium\\_development\\_goals/about/en/](https://www.who.int/topics/millennium_development_goals/about/en/)> (accessed on October 1, 2019)

reduce child mortality and the improvement of maternal health.<sup>108</sup> Between the period set out for realisation of the commitments made to realise the MDGs, the global maternal mortality rate (MMR) decreased by 44% from 385 to 216 maternal deaths per 100, 000 live births.<sup>109</sup> It is pertinent to note that despite the global average decrease huge inequalities persisted regionally. In Sub Saharan Africa the highest MMR was envisaged at 546 maternal deaths per 100, 000 live births with developed regions citing 12 maternal deaths per 100, 000 live births.<sup>110</sup>

Consequently, under the SDGs the reduction of maternal mortality remains a priority. Under SDG 3 it provides for a commitment to ensure healthy lives and promote well-being for all at all ages in line with the increasingly adopted holistic definition by the WHO which states being the state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.<sup>111</sup> Kenya in 2016 experienced a MMR of 362 in every 100,000 live births. Consequently, Kenya under its SDG Country commitment is obligated as a country to reduce its MMR at country level by at least two thirds by 2030 as per the SDGs timeline.<sup>112</sup>

### **3.2.1 Maternal Health**

Globally, in the 1960s the feminist movement began to attach great importance and priority to reproductive freedom. This was largely driven by a fast rising discourse surrounding birth control and the growing opposition against women's individual liberty and sexual equality. Author Kay in *Feminist Jurisprudence* thus posits that to treat persons who are different alike is

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<sup>108</sup> Ibid

<sup>109</sup> The Sustainable Development Goals and Maternal Mortality < <https://www.ijcmph.com/index.php/ijcmph> > accessed on October 1, 2019

<sup>110</sup> Ibid

<sup>111</sup> World Health Organisation, < <https://www.who.int> > about > who-we-are > frequently-asked-questions> accessed on October 1, 2019

<sup>112</sup> World Health Organisation, *Strategies Towards Ending Preventable Maternal Mortality* (February 2015)

to treat them unequally hence reintroducing our earlier discourse on Rawls and Justice. The author asserts that women are treated unequally not due to an innate difference in ability but as a result of conditions or circumstances that hinder certain uses or development of certain abilities. Conditions that are normalized as practice by society.<sup>113</sup>

Hence, you may have a legal provision providing for a right or fundamental freedom aimed at promoting equality in one way or the other but due to the lack of consideration of the conditioning attributed to its formulation and on the flip side – its implementation, it winds up creating a greater or different state of inequality altogether. This scenario resounds true of the state of RH care.

Maternal health has been defined by the WHO as the health of women during pregnancy, childbirth and the postpartum period.<sup>114</sup> Kenya has internally recorded extensive violations with due regard to SRHR. This was cited as a key finding by the KNCHR in its findings from a national inquiry investigating complaints forwarded by CSO on behalf of communities.<sup>115</sup>

According to the inquiry report, maternal mortality indicators have continued to show a negative trend in the past ten years, MMR has increased from 414 per 100,000 live births to 488 deaths.<sup>116</sup>

According to the KDHS 2008-09, maternal deaths represent about 15% of all deaths of women aged 15-49 in Kenya. This is approximately 8,000 women dying annually from complications related to pregnancy and childbirth. These findings can be compared to those of the KDHS 2014 that highlight data findings to the tune of, maternal deaths representing about 14 percent of all

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<sup>113</sup> Herma Hill Kay, 'Equality and Difference: The Case of Pregnancy' in Patricia Smith *Feminist Jurisprudence* (OUP 1993) 37 < <https://scholarship.law.berkeley.edu/> > accessed on 17 December, 2019.

<sup>114</sup> World Health Organization, < <https://www.who.int/maternal-health/en/> > accessed on October 1, 2019

<sup>115</sup> The Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Health Rights in Kenya A myth or Reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya*, April 2012.

deaths among women age 15-49, the designated reproductive ages. The percentage of female deaths that are maternal varies by age from about 5 percent among women age 45-49 to 27 percent among women age 25-29.<sup>117</sup>

Though the inquiry by KNCHR released its findings two years before those documented under the KDHS, the former's findings are reflected in the rolling research that informs the collation of findings in the KDHS. In the KNCHR Report, the findings also include a detailed breakdown of what maternal health care looks like on the ground and through the lens of an ordinary Kenyan. Consequently, from witness accounts and reports from various non-governmental organisations there was evidence of a lack of basic supplies such as cotton wool, pads, gloves, syringes, surgical blades, material to wrap babies, anesthesia, disinfectant, medicines, bed sheets and blankets compounded with dirty and unhygienic conditions where a common trend of women being forced to share or sleep on the beds was discovered and the lack of bathing water and consequent sanitation issues. These findings echo the testimonials shared in the Maimuna Case.

A witness who lost their wife at a faith based health center in Nairobi called Maria Immaculata, testified during the inquiry that:-

“There was blood all over; she had lost a lot of blood. Blood was being drained into a bucket, the bed was covered with blood, and blood was gushing out from her birth canal like a stream of water. I asked the medics why they could not have put a piece of cloth or cotton wool to arrest the bleeding...they ignored me, at this time, she started shaking vigorously, I held her on my arms, felt her pulse rate and sensed danger. Something was terribly wrong! I still cry to date. I was not ready for what I saw. Imagine seeing someone

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<sup>117</sup> Ibid (n14) 257

you love so much, a person who had become part of your life dying. Worse is the painful fact that her death could have been prevented. What I saw was extremely terrifying. It runs in my mind throughout the day, every day. It gives me a lot of pain and anger against those medics...'<sup>118</sup>

The inquiry report indicates that the panel contacted the resident doctor in the aforementioned matter who indicated that on being called to tend to the emergency situation, he found that the patient had lost too much blood and the Maria Immaculata facility did not have any in stock but had sent for more at the Kenyatta National Hospital. However, the ambulance was delayed due to traffic jam in Nairobi (sic).<sup>119</sup>

These findings of the inquiry, with the aforementioned testimony included, are evidence of a broken health care system whence measured against the WHO Pillars of a good health system which include; health service delivery, health workforce, health information services, access to essential medicines, health systems financing and leadership and governance. As expounded by CESCR in General Comment No. 14. This is an obligation entirely carried by the state to ensure health professionals meet appropriate standards of education, skill and ethical codes of conduct<sup>120</sup>; that states foster a conducive environment to favour positive health results.<sup>121</sup>

### **3.2.2 Access to Contraceptives**

The old adage 'never trust a male' applies particularly to birth control. After all, it is not the man who becomes pregnant. For many women across a myriad of societies, the decision on contraception is undertaken by a man, this is especially true in developing countries where male

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<sup>118</sup> Ibid 78

<sup>119</sup> Ibid 78

<sup>120</sup> Ibid (n58) Para 35

<sup>121</sup> Ibid para 37

dominance is prevalent and dominant in sexual matters. Audre Lorde stresses that women have been encouraged to recognize only one area of human difference, those that exist between women and men. This perception has been propagated as a tool for social control. Consequently, the right to RH care and access to relevant services is construed from this lens by the women and girls in need of these services. Thus despite the existence of a law enshrining a human right aimed at addressing a historical inequality its implementation is plagued still by inequalities. Lorde urges that the future survival of women is predicated upon our ability to relate within equality – this is predetermined by approaching equality not from a uniformity point of view.<sup>122</sup>

The ICPD Programme of Action that was adopted under the auspices of the first ICPD Conference, emphasises the importance of individual's autonomy and choice in selecting when they want to have children and how many. In the 20<sup>th</sup> anniversary edition of the ICPD Programme of Action, emphasis is made on the adoption of a holistic and comprehensive provision of RH and services most especially on contraceptives and family planning. These two terms are used interchangeably in this chapter due to the problematic nuances they encounter in the Kenyan SRHR context.

The ICPD Programme of Action also emphasises on the involvement of men in RH and information campaigns due to the high demographic of adolescents in need of improved access to contraceptives and RH services and information.<sup>123</sup> The ICPD Programme of Action highlighted that family planning has contributed significantly in the decline of average fertility plans in developing countries in contrast to the 1960s. However, it noted that the full range of modern family planning methods remain unavailable to at the very least 350 million couples

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<sup>122</sup> Christine A. Littleton, 'Reconstructing Sexual Equality' in Patricia Smith *Feminist Jurisprudence* (OUP 1993) 118

<sup>123</sup> *Ibid* (n26) 78 para 7.8

worldwide many of whom would want to avoid another pregnancy or avoid one.<sup>124</sup> Adolescents are identified within the ICPD Programme of Action as a target demographic that has been significantly overlooked with due regard to access to sexual and RH care and rights. It emphasises that information and services should be availed to help adolescents understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and the consequent risk of infertility.<sup>125</sup> Family planning and contraceptives also enable women and girls to exercise choice and control over their fertility and advance gender equality and increased opportunities for education, employment and full participation in society.<sup>126</sup>

Kenya which has adopted the ICPD Programme of Action pledged to meet the needs of adolescents and to respond to their SRH needs and that of the general Kenyan population.<sup>127</sup>

Kenya has in the past few years has had an upsurge of early unintended pregnancies amongst adolescents. This becomes a key observation towards the end of the year with the registration of young school going adolescents for their primary level national examinations. About half of all adolescent pregnancies (15-19 years) in developing regions are unintended and more than half of them end in unsafe abortions.<sup>128</sup>

Key violations with due regard to family planning and contraceptive access have been identified. They include a prevailing unavailability of family planning commodities in health facilities demonstrated by reports of frequent stock outs; structural barriers that prevent village community health workers from carrying emergency contraceptives or directly offering injectables and unavailability of long term contraceptives methods in lower level facilities; cultural norms and

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<sup>124</sup> Ibid 79 para 7.13

<sup>125</sup> Ibid 88 para 7.41

<sup>126</sup> Ibid (n58) 18

<sup>127</sup> Ibid 90 para 7.47

<sup>128</sup> Darroch E.J et al, *Adding it Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents*, (Guttmacher Institute 2016)1

practices that place family planning decisions on the man and rob the woman of their right to autonomy and choice; misinformation, myths and misconceptions on family planning and contraception and; perceptions on high costs for access to contraception that negate the majority poor.<sup>129</sup>

The inquiry by KNCHR on highlighting the resultant situation of women and girls when faced with structural and cultural barriers leads to the growth of a culture of fear and stigma which in some instances leads to unsafe abortions, which shall be covered in the next sub-section.

### **3.2.3 Access to Safe and Legal Abortion**

The introduction of a paper published by the WHO on legislation surrounding abortion states that “*Abortion is the dreaded secret of our society...that remains untouched and undiscussed....*” borrowed from the works of Lader on abortion in 1966.<sup>130</sup> Whilst this has considerably changed in a substantive number of countries across the developed world, it rings true for most African countries. This is despite the collation of data indelibly connecting a significant number of maternal morbidity and mortality cases to unsafe abortions.

Global estimates cite that 25.1 million women had undergone an unsafe abortion annually between 2010 and 2014.<sup>131</sup> Unsafe abortion is defined as a termination of pregnancy by persons lacking necessary skills or in an environment lacking minimal standards or both. It is cited as one of the leading causes of high MMR in Kenya.<sup>132</sup> A study by the Ministry of Health, IPAS and APHRC found that in 2012 464,000 unsafe abortions were induced translating into 48 per 1,000

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<sup>129</sup> Ibid p.19

<sup>130</sup> World Health Organisation, *Abortion Laws - A Survey of Current World Legislation* (Geneva 1971)

<sup>131</sup> Calvert C, Owolabi OO, Yeung F, et al. et al, *The magnitude and severity of abortion-related morbidity in settings with limited access to abortion services: a systematic review and meta-regression*, (BMJ Global Health, 2018) 1

<sup>132</sup> Sexual and Reproductive Health – Preventing Unsafe Abortions

<[https://www.who.int/reproductivehealth/topics/unsafe\\_abortion/hrpwork/en/](https://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/)> accessed on October 3, 2019



women aged 15-49 years. Almost half (49%) of all pregnancies in Kenya were unintended and 41% of them ended in an abortion.<sup>133</sup>

Lack of safe and legal abortion services in Kenya is occasioned by a lack of clarity in the law and high instances of stigma forcing women and girls in dire need of abortion services to resort to the crudest methods. These have been found to include; taking traditional herbs or high doses of anti-malarial drugs or strong concoctions of tea leaves, bleaching solutions. In extreme cases women have inserted needles or sticks through the vagina, the use and insertion of catheters, pipes, coils or wires, pens and ingesting dangerous substances altogether.<sup>134</sup> As demonstrated in Petition 266 of 2015, criminalization is a key driver of unsafe abortion due to fear by both the patient and qualified medical provider creating a gap for quacks to thrive and offer unsafe abortions. The five judge bench highlighted this in depth in the progressive judgement in the aforementioned case of JMM.<sup>135</sup>

The CoK under Article 26(4) provides for parameters within which safe and legal abortion can be provided and accessed. However, provisions in the Penal Code criminalise abortion in its totality. These are sections 158-160.<sup>136</sup> In a twist, the same penal code covers medical providers in instances of performing an abortion as a medical procedure as provided under section 240.

The aforementioned conundrum has led to a cloud of confusion amongst law enforcers a fact that has been highlighted by various non state actors. They opine that the lack of clarity on the law amongst law enforcement and ODPP in Kenya, many cases riding on abortion charges do not have ingredients proving the guilt of accused providers and women beyond reasonable doubt.

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<sup>133</sup> Ministry of Health, African Population and Health Research Center and Ipas, *The Costs of Treating Unsafe Abortion Complications in Public Health Facilities in Kenya*, APHRC, Kenya 2018.

<sup>134</sup> Ibid (n58) 47

<sup>135</sup> Ibid (n40)128-130

<sup>136</sup> Penal Code, Laws of Kenya Cap 63 Sections 158 - 160

Another prominent trend has been the use of charges beyond 158-160 to charge women who are alleged to have procured an illegal abortion. These provisions were highlighted in a compendium of abortion related cases as part of findings by a study commissioned by KELIN<sup>137</sup>. They include section 227 and 228 that provide for the charges of concealing birth and the killing of an unborn child respectively and also section 210 which provides for the crime of infanticide.

The study also revealed a trend from the cases that were sampled from court registries in Kisumu, Kilifi and Nairobi counties, that most of these criminal cases were concluded by virtue of *nolle prosequi* and that the number of cases ruled on did not take into consideration the provisions under the Constitution on parameters allowing access to safe abortion and that most cases brought to court were prevalent in rural and peri-urban areas as opposed to urban towns.<sup>138</sup>

The latter speaking to the economic barriers envisaged in access to comprehensive and quality RH care services.

In addition, the criminalization of safe access to abortion within the parameters of Article 26(4) goes against the ‘Do no Harm’ principle that is generally used to demonstrate the precarious linkage between criminalization and human dignity ergo human rights. It is posited that criminal law must protect the citizen from what is ‘offensive or injurious’ but must not otherwise intervene in the private lives of citizens. The No Harm Principle was first developed through the findings of the Wolfenden Commission adjudicating on matters of same sex relations and prostitution. Moving forward this is a notion quite relevant and significant to the women’s’ reproductive movement where contestations of characterizations of abortion as harmful to

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<sup>137</sup> Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) *Research Documenting the Practice of Prosecution of Women and Medical Providers Post Enactment of Article 26(4) on Access to Abortions since 2010*, 2018

<sup>138</sup> Ibid p.5

women and society are continually brought forward in a bid to reclaim women's equality and reproductive emancipation.

### 3.2.4 Chapter Summary

All throughout this paper individualism has provided an underlying foundation in the assertion of human dignity and its subsequent transition into the right to RH care. As envisaged in the three RH components highlighted in depth in this chapter the realization of the right to RH care seems to only aggravate the existing pain of most, if not all women, and it is indelibly grounded in inequality and unequal treatment. Consequently, discrimination persists across an intersectionality of individual pain or inequality be it poverty, illiteracy or even geographical barriers. Subsequently, these are questions of justice, not science, filled with complexities that evidence the real impact of inequalities.<sup>139</sup>

Arguably, one of the key evidences as evidenced in the findings around access to safe abortion within the parameters of the law is the prevalence of its blanket criminalisation. The conventional foundation on discussions around morality, privacy and the law revolves around John Stuart Mill's writings *On Liberty* where he comprehensively draws out the 'Harm Principle' which asserts autonomy and distinguishes the extent of interference of the so called 'moral offenses'.<sup>140</sup>

Given the prevailing bleak statistics relevant to the six broad areas constituting a budding health system, the state finds itself in a precarious position where the evidence of a shaky health system points towards a lack of structured and intentional realization of the right to RH care. With no

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<sup>139</sup> Martha Minow, 'Justice Engendered', in Patricia Smith *Feminist Jurisprudence* (OUP 1993) 217

<sup>140</sup> Ali Jernow, 'The Harm Principle Meets Morality Offenses: Human Rights, Criminal Law, and the Regulation of Sex and Gender' in Alice M. Miller and Mindy Jane Roseman (eds), *Beyond Virtue and Vice: Rethinking Human Rights and Criminal Law* (PENN 2019)54

clear requirement for state responsibility to show that resources are unavailable or to monitor the realization of the right to RH care, there is no reprieve in sight for women and girls in Kenya.

## CHAPTER FOUR

### LESSONS FROM COUNTRIES THAT HAVE CONSTITUTIONALISED THE RIGHT TO HEALTH AND REPRODUCTIVE HEALTH CARE

#### Introduction

This chapter will highlight the practices of a country each, from the African and Latin American regions. These two case studies, South Africa and Ecuador have both constitutionalized the right to RH care and other reproductive rights extensively and are also located in continents where strong opposition has been highlighted with due regard to SRHR.<sup>141</sup>

From Eastern Europe to Latin America to Africa, supreme and constitutional courts have taken their place, as envisaged for Kenya too under Chapter two, in enforcing a new constitutional order. Author Esteban asserts that this has led to judicial activism grounded in fundamental rights and freedoms guaranteed through these Constitutions and a subsequent constitutionalisation of the law. Resulting in a scenario where every sub-tenet of the law is encompassed therein and as such the *grundnorm* provides overall guidance and a threshold to measure compliance.<sup>142</sup>

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<sup>141</sup> Ibid (n49) 15

<sup>142</sup> Esteban Restrep Saldarriaga, 'Poisoned Gifts: Old Moralities under New Clothes?' in Alice M. Miller and Mindy Jane Roseman (eds), *Beyond Virtue and Vice: Rethinking Human Rights and Criminal Law* (PENN 2019) 197

The Constitution of Kenya and its inclusion of Socio-Economic rights was and continues to be hailed as setting a foundation for a progressive constitutional era. The inclusion of Socio-Economic rights within Chapter Four of the Constitution of Kenya thus establishes the justiciability of these rights. Subsequently, this ensures their highest protection is guaranteed and a formidable opportunity to develop a solid jurisprudence *vide* judicial interpretation is assured though not entirely, thus enabling a better understanding on the nature and scope of these rights in implementation. This ensures that all stakeholders – citizenry as right holders and the states as duty bearers - are obsequious to the requirements for these rights to be enjoyed by all.<sup>143</sup>

Author Japhet Biegon draws an important distinction in the analysis of Socio-Economic rights as justiciable rights. Kenya's framing of Article 43 – in its entirety and as the key carrier of Socio-Economic rights – does not use language to impute internal limitations to the enjoyment of the right to health, amongst others<sup>144</sup>. An example of internal limitations can be highlighted through the example of the South African Constitution which adopt limiting framing with due regard to Socio-Economic Rights. For example, the Constitution of South Africa under its Bill of Rights states that everyone has the right to have *access to* health care, including RH care whilst Kenya by not including the term *access* under the right to health alludes to the trend of *dismantling the dichotomy* of Human Rights and reinforces their universality, indivisibility, interdependence and interrelatedness.<sup>145</sup> Hence, the ever present conundrum with the comfort that arises from the progressive implementation of Socio-Economic Rights.

An affirming excerpt on the persisting tensions on the dichotomy of rights and the inherent indivisibility of human rights, highlights that for a state - through the power of its citizenry- to

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<sup>143</sup> Ibid (n29) 27

<sup>144</sup> Ibid (n5) Article 43

<sup>145</sup> Ibid 19,28

include Socio-Economic Rights in the Bill of Rights of a Constitution thus affirming their justiciability cannot then turn around and state that these rights are merely aspirations that cannot be enforced. This justification largely adopted due to the advisory opinion pronounced by CESCR under General Comment 14, is skewed and is not a reflection of the requirement of intentionality in the realization of Socio-Economic Rights in general and quite specifically the right to health and RH care. It may otherwise be perceived that the intent of including Socio-Economic Rights within the Bill of Rights was a mere hoax to the citizenry.<sup>146</sup> However, different jurisdictions portray a different picture and it is pertinent to draw comparison with the intent of identifying lessons and borrowing best practices.

#### **4.1 South Africa**

The Right to access Health Care Services and RH Care is enshrined under Article 27 in the Bill of Rights in the South African Constitution. The provision also emphasizes that the state must take reasonable legislative and other measures within its available resources, to achieve the realization of each of these rights.<sup>147</sup> Democratization in South Africa and the monumental abolition of apartheid, played a central role in the recognition of equal access to health care for all South Africans regardless of their race.

In the mid-1980s the apartheid system had conventionally established fourteen departments of health across the country. Under the independent homeland system commonly referred to as

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<sup>146</sup> Ibid 33

<sup>147</sup> Constitution of the Republic of South Africa, 1996 Article 27

*Bantustan* there existed independent departments of health with the main South Africa having a three tier system of governance including health.<sup>148</sup>

Subsequently, health rights may be conceptualized and contextualized within the country's transition from a white majority rule to a constitutional democracy with the rule of majority representation prevailed and still does.<sup>149</sup> Under apartheid there were three different types of health departments developed to offer services to three classifications of South Africans namely; the whites, coloreds and Indians testament of the extent of apartheid in governance and the infringement of human rights, the basic and most important foundation being the treatment of all persons with dignity.<sup>150</sup>

Reproductive rights in South Africa have been focused on equality as a reflection of its post-apartheid constitutional journey. The SA Constitution explicitly provides for the right to privacy, equality and non-discrimination. Article 12 (2) of the SA Constitution provides for every person's right to physical and bodily integrity including the right to make decisions concerning reproduction and to security in and control over their body.<sup>151</sup>

As was the general trend in the field of SRHR, and in some instances still is, the core focus with due regard to the realization of the right to RH care was mainly a focus on maternal services and HIV centered interventions. However, the impact and effect of platforms and resolutions such as those that featured in the ICPD 1994 and Beijing Conference catalyzed the continual growth and

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<sup>148</sup> Contextualizing the Struggle of Health Workers in South Africa Global in *Global Health Watch* (GHW 5 2017) 119

<sup>149</sup> Carole Cooper, 'Health Rights Litigation: Cautious Constitutionalism', in Alicia Ely Yamin and Siri Gloppen *Litigating Health Rights: Can Courts Bring More Justice to Health?* Harvard University Press (2011) p. 190

<sup>150</sup> Diane Cooper et al, *Ten years of Democracy in Africa*, Reproductive Health Matters, (2004) 1-2

<sup>151</sup> <sup>151</sup> Constitution of the Republic of South Africa, 1996 Article 12

enrichening of state interventions and policies centered on realizing the right to RH care in South Africa.<sup>152</sup>

South Africa made some notable international and regional commitments that aided the realization of the right to RH care: 1994 – the establishment of a free maternal health program for all pregnant women; 1995 the government ratified the CEDAW; 1996 – it enacted the Choice on Termination of Pregnancy that provided a detailed legal framework in the provision of safe and legal abortion services; 1997 – Maternal death was established as a notifiable condition and the launch of the Patients’ Rights Charter was launched with the intent of giving patients knowledge and opportunity to raise and have addresses issues of quality in the provision of health services; 1998 – the SA National AIDS Council was formed and the enactment of the Domestic Violence Act; 2002 – the SA government launched National Contraception Policy Guidelines and also approved the provision of HIV post-exposure prophylaxis to rape survivors in public sector facilities; 2003 – approved provision of ARVs to people living positively through public sector health services and; 2004 proposed reviews on the definition of rape in the sexual offenses act which still had its colonial framing, a proposal that was finally realized through the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 expanding the offense of rape to be applicable to all forms of penetration without consent and irrespective of gender. The latter key amendment is a key example of the intrinsic linkage between SGBV and RH Justice as discussed earlier under Chapter two.<sup>153</sup>

South Africa remains a beacon of hope for most African countries with due regard to the enactment of progressive legislation at national level and a similarly reformist constitutional

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<sup>152</sup> Ibid 3-4

<sup>153</sup> Ibid 4



court developing formidable jurisprudence. However, a key observation over the years of legislative process is the overall data statistics on health indicators – key among them RH care.

The social determinants of health generally include sanitation, housing, decent and safe work, a clean environment, water and food. However, South Africans' access to the aforementioned, with the resultant aim of realizing their right to health and specifically the right to RH care, remains dismal in view of its economic classification as an upper middle class economy. There is continuing evidence across the divide that affirms the initial trends during apartheid – access is stratified based on race and class. With due regard to the latter, vested interests submerged in selfish political and economic class opportunism including the desertion of the Reconstruction and Development Programme (RDP) and the adoption of neoliberal macroeconomic policies.<sup>154</sup>

A clear indication of the importance of a synergized approach by state and citizenry across political, economic and social barriers towards the realization of human rights.

Population health is in most instances better in richer than poor countries – poor and unhealthy and rich and healthy. SA does not fall within this band where you have poor countries like Bangladesh, Kenya, Ghana and Rwanda having much better health outcomes. Country economic ratings tend to hide underlying issues that inhibit or interfere with the implementation of rights and a reflection of a citizenry that is clearly benefiting from good laws. South Africans endure or undergo an immense burden of diseases attributable to certain health categories. Key among them are; HIV/AIDS, Tuberculosis and other infections, high maternal and child mortality, high levels of violence and injuries including high incidences of violence against women

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<sup>154</sup> Ibid (n122) 121

(SGBV,GBV), increasing lifestyle diseases (NCDs) such as obesity, heart disease, diabetes and cancer.<sup>155</sup>

There is a clear indication of a gap between the law and implementation in South Africa, with key lessons that can be borrowed in the Kenyan context towards the proper implementation of the right to RH. With due regard to access to contraception there continues to prevail a lack of health information.<sup>156</sup>

Another key barrier that has been identified is the somewhat hampered implementation or ‘acceptance’ of the progressive provisions of the Choice on Termination of Pregnancy Act which provide extensively on access to safe and legal abortions. Firstly, due to the stigma mentioned above on access to contraception youngest women end up with unplanned pregnancies and as such represent the key data group in terms of accessing abortion services.<sup>157</sup>

Secondly, there have been judicial challenges towards the implementation of the Choice on Termination Pregnancy Act which expands on the right to RH care within the SA Constitution by providing a detailed framework for the right of women to access safe abortion. The Act provides for unconditional abortions in the first trimester and for abortions in limited circumstances including exposure to mental and physical health issues and instances of social or economic circumstances that lead to the woman seeking to access this service at a gestational period below 20 weeks. These challenges have proved unsuccessful but have drawn out a continued debate between the law and its realization.

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<sup>155</sup> Ibid 120

<sup>156</sup> Ibid (n124) 6

<sup>157</sup> Ibid 6

In the case of the Christian Lawyers Association against the SA Ministry of Health<sup>158</sup>, the Transvaal High Court considered whether the right to choose should be protected under the fundamental freedom and right of dignity and privacy as enshrined in the SA Constitution and decided that it was not necessary to resort to general guarantees and that the right to RH care enshrined within the Constitution was adequate to protect the woman's right to reproductive self-determination.

In general, South Africa's dimming results in the realization of the right to health and with its most recent approach and challenges towards establishing Universal Health Coverage for all do not present a budding system for the right to RH care specifically. They have adopted a similar approach as that which is being experienced in Kenya and the larger international space with due regard to the recognition and adoption of SRHR progressive language in the Universal Health Coverage of Health in the political declaration of the UNHLM on UHC.<sup>159</sup>

## 4.2 Ecuador

Latin American countries have been highlighted as to have one of the most restrictive laws and policies on RH rights and quite prominently dismal RH outcomes quite specifically with due regard to the right to access safe and legal abortion.<sup>160</sup> Until June 2017, abortion under any circumstances was still prohibited in five of the 195 member states of the United Nations. Four of these countries were Latin American countries and included; The Dominican Republic, El

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<sup>158</sup> Christian Lawyers Association v National Minister of Health and Others 2004 (10) BCLR 1086 (T) (South Africa) < <https://ipas.org/> > accessed on 17 December 2019

<sup>159</sup> David Branigan, 'US Faces Off Against 43 Countries on Sexual and Reproductive Health and Rights', < <https://www.healthpolicy-watch.org/us-faces-off-against-43-countries-on-sexual-reproductive-health-rights/> > accessed 4 October 2019 at 1848 Hours.

<sup>160</sup> *Abortion and Reproductive Rights in Latin America: Implications for Democracy*, (Center for Reproductive Rights, 2015) 5

Salvador, Nicaragua and Chile.<sup>161</sup> Ecuador is one of the few Latin American countries to provide for the right to RH care and provision of free emergency contraception but quite notably bans access to safe abortion within any context and has further criminalized it with recorded cases of imprisonment of women and girls.<sup>162</sup>

Under its Constitution, Ecuador provides for the right to RH care under article 66 and reinforcing this through article 332 which guarantees comprehensive SRHR and care for all workers. The aforementioned is highlighted as quite a comprehensive and expanded scope of constitutionalised legal provisions reinforcing the right to RH care.<sup>163</sup>

Additionally, it also provides for the right to decide how many children to have<sup>164</sup> and enshrines the right to sexual health by encapsulating the right to make decisions over one's sexual life and orientation under article 66(9) and tasks the state with the responsibility to fulfill this right by promoting access to the means to make a decision about one's sexual orientation in safe conditions.<sup>165</sup> Summarily, Ecuador's Constitution, vast as it is, has comprehensively entrenched various components of SRHR including the right to RH care, but not limited to it. As highlighted above, sexual health is a core component of SRHR provided for by the Constitution. Whilst this is not a seemingly unique trend it is neither a commonality.

In 1998, Ecuador passed the Free Maternity Law guaranteeing free maternal health care to pregnant women and newborns, promoting access to family planning and the standard free healthcare to children under the age of five years. Notably, the law applies only to women of

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<sup>161</sup> Maria Galarza, 'Dissenting Fiction Re-Righting Law: practice-led research into biopolitics, women's rights and reproductive justice in Ecuador' University of Melbourne (2017) 25 [Submitted to Facultad Latinoamericana de Ciencias Sociales (FLACSO) - Sede Ecuador]

<sup>162</sup> *Women's Reproductive and Sexual Health as a Human Rights*, Child Family Health International

<sup>163</sup> Constitution of the Republic of Ecuador, 2008 Article 32 and 363

<sup>164</sup> *Ibid* Article 66(10)

<sup>165</sup> *Ibid* Article 66(9)

reproductive ages 15-49 years. This law was envisaged as giving life to the right to RH care enshrined in Ecuador's Constitution.

Quite notably however, Ecuador like many countries has a good Constitution but realization of the right to RH care has proven difficult and in some instances even unfair. Ecuador has restrictive provisions with due regard to access to safe abortion. Its criminal code partially allows for abortion, however, it therein imposes penalties and criminalizes any other instances where a woman or girl can seek safe abortion services aside from those highlighted.<sup>166</sup> The restrictive provision allowing abortion only where a woman has a mental disability is quite a conundrum given high instances of sexual and gender based violence in the country. This is one of the key areas that was highlighted by the IACHR Paola Del Rosario case<sup>167</sup> against Ecuador that accuses the state of failing in its obligation to protect a young girl who was sexually abused and eventually committed suicide, through a failure to protect her from acts of harassment and sexual abuse, failure to provide the necessary medical care and delays in criminal prosecution to her detriment.<sup>168</sup> However, it is pertinent to note that the Pact of San Jose of which Ecuador is a party to under the Organisation of American States, provides for a broader obligation by the state to protect life from conception.

Ecuadorian author and scholar Maria Galarza highlights the legal conundrum that plagues Ecuador with due regard to enforcing the RH care for its citizenry on the one hand and the blatant criminalisation of women who seek or seem to have accessed abortion. She posits that

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<sup>166</sup> *Ecuador: Memorandum on Abortion and International Human Rights Law*, Human Rights Watch <<https://www.hrw.org/news/2019/04/25/ecuador-memorandum-abortion-and-international-human-rights-law>> accessed 5 October, 2019 at 1252 Hours

<sup>167</sup> Report No. 76/08 Admissibility of Petition 1055-06 Paola Del Rosario Guzman Albarracin and Next of Kin v Ecuador (2008) para 1 <<http://cidh.org/annualrep/2008eng/Ecuador1055-06eng.htm>> accessed 5 October, 2019 at 1302 Hours

<sup>168</sup> Ibid

under Article 45 of the Ecuadorian Constitution it provides for the protection of the rights of the child but further states that the state shall recognize and guarantee life, including care and protection from the time of conception. This Constitutional provision, she states, infers to an equation of intra-uterine life with the value of life after birth.<sup>169</sup> In addition, Article 44 of the same Constitution provides for the upholding of the best interests of the child. The forestated Constitutional Conflict as read alongside the Comprehensive Organic Criminal Code has led to the continued criminalization of women who seek or need to access safe abortion services. Consequently, this continues to result in the denial of women's enjoyment of their fundamental rights.

### **4.3 Chapter Summary**

Reproductive Justice is posited to feature or encompass three major decisions grounded on bodily autonomy. These include; the right to have a child, the right not to have a child and the right to parent children in a safe and healthy environment. Understanding the normative intent of reproductive rights results in having an intersectional perspective which nuances significantly around social justice. In addition, this holistic lens leads to the realization that Socio-Economic rights, as do all human rights, are interdependent and interrelated.<sup>170</sup>

With due regard to the South African case it is laudable that they have extensively provided for the right to RH care and a vast array of reproductive rights within the Constitution and national legislation. However, the challenges in the realization of these legal provisions is a worrying trend and is a resounding similarity to the Kenyan situation. The progressive nature of the SA Constitutional Court remains unparalleled in the African context and Kenya is closely following

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<sup>169</sup> Ibid (n148) 24

<sup>170</sup> Ibid (n148) 36

suit post the Constitution 2010. However, a pertinent observation is made by Japhet Beigon where he asserts that the SA Constitutional Court seems to take a cautious approach in an attempt to maintain an appropriate constitutional balance. Consequently, it has been seen to evade making decisions that touch on budgetary allocation while upholding the court's mandate to promoting social justice. The case of TAC evidences this because the court stated that their role as the judicial arm of government was to merely measure state actor's reasonableness through judicial evaluation.<sup>171</sup>

Ecuador presents a scenario with a worrying trajectory in terms of realizing the right to RH care for its citizenry but most especially women and girls. Specifically, its trajectory continually laying emphasis on the personhood of a foetus over the life of the woman carrying the foetus is a worrying and problematic trend. This has automatically led to the criminalization of women who need access to safe abortion whether due to spontaneous or induced occurrences which would call for post abortion care. Women have been charged, prosecuted and imprisoned.

Author Maria Galarza in her creative analysis of the Ecuadorian state of RH interrogates the aforementioned practices and asserts the continued adoption of coercive mothering or motherhood as a means to deny women their reproductive rights and propagate further reproductive injustices despite the right to RH care and various other reproductive rights reinforcing autonomy, being provided for in the Ecuadorian Constitution. Consequently, Ecuador presents a situation that most countries including Kenya would not want to find themselves in. There is a clear discordance between the law and its implementation on the ground which continues to propagate reproductive injustices to the women and girls of Ecuador.

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<sup>171</sup> Japhet Beigon, 'The Inclusion of Socio-Economic Rights in the 2010 Constitution: Conceptual and Practical Issues' in Japhet Beigon and Godfrey M. Musila (eds) *Judicial Enforcement of Socio-Economic Rights Under the New Constitution: Challenges and Opportunities for Kenya* (Judiciary Watch Report Series by the Kenyan Section of the International Commission of Jurists) Vol. 10 (2011) 45-46

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.3 SUMMARY OF FINDINGS**

The nuances drawn from the Constitution with due regard to the lack of use of the wording ‘right to access’ speaks volumes to the letter and the spirit of Article 43(1)(a). As highlighted under section one of this chapter the latter framing points towards the inclusivity of an internal barrier or contributing circumstances thereto. However, the Kenyan provision on the right to RH care envisaged a scenario where all Kenyans would enjoy their right to health and as relevant to this study’s discourse, their right to RH care.

The principal ‘burden’ on the implementation of the right to RH care lies on the state.<sup>172</sup> In Kenya’s case with the fact that the right to health is devolved to the forty seven counties and as such there exists a shared duty between the national and county governments. Thus both levels of

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<sup>172</sup> Ibid (n58) para 33



government must be lauded or held accountable for any progresses or failure to respect, protect and fulfill the right to RH care.

In essence and as highlighted under Chapter two of this study, a young JMM<sup>173</sup> should not have failed to receive adequate medical care after being defiled, subsequently procuring an unsafe abortion and due to arbitrary and unwarranted withdrawal of standards and guidelines, failed to receive proper and adequate post abortion care. Secondly, women and girls in Kenya continue to lack affordable(available), accessible, acceptable and quality maternal health care. This is in spite of the existence of comprehensive national laws, international laws and treaties that Kenya has signed onto to protect, respect and fulfill their obligations to the people of Kenya with due regard to them enjoying their highest attainable standards of health including RH care. As highlighted in the Maimuna case<sup>174</sup>, the petitioners were well aware of the challenges of the health system with due regard to RH care and whilst they did their very best to plan within their Socio-Economic circumstances the system failed them and as a result violated a myriad of their constitutional rights and quite significantly their right to RH care.

In addition, the continuous dismal statistics on the various components of RH, as highlighted through the collated national health data in the KDHS are an indication of a system that needs continuous improvement. Women and girls are and have been part of marginalized and vulnerable groups over time most especially with due regard to their enjoyment of Socio-Economic rights. Dr. Nicholas Orago best surmises the predicament that women and girls in Kenya find themselves due to the very patriarchal nature of our Kenyan Society. Violence occurs in the entire life cycle of a woman from birth to death. It is seen in instances of infanticides and

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<sup>173</sup> Ibid (n70)

<sup>174</sup> Ibid (n64)

the selective abortion of girls, femicides, sexual and gender based violence and trafficking for sexual exploitation, unpaid care work (domestic work), forced prostitution. Female genital cutting, forced marriages, dowry violence, domestic violence, marital rape (that is not penalized in Kenyan law but provided for under the Protection Against Domestic Violence Act, 2015) and sexual harassment.<sup>175</sup>

#### **4.4 CONCLUSION**

Respect for the right to RH care includes the prohibition of all forms of discrimination against women and the change of laws and other instruments that act as a tool of oppression against the reproductive autonomy of women and girls.<sup>176</sup> However, in instances such as Kenya's where the law in its letter and spirit requires and adequately provides for the right to RH care, then other measure must be considered and put in place – for oversight, monitoring and evaluation. It is evident from the findings of this paper, that the missing link is the State's skewed perception of implementation of the Constitution's Article 43(1)(a) that they attribute to principle of progressive implementation.

CESCR highlights that the notion of the highest attainable standard of health as provided for under Article 12 of the ICESCR takes into consideration an individual's biological and Socio-Economic precondition vis a vis a state's available resources. It goes on to highlight that there are components that cannot be addressed singularly within the relationship of a state and an individual such as protection from individual circumstances and choices freely made that lead to ill health like genetic dispositions that lead to ill health. Consequently, it emphasizes the need to conceptualize the right to health as enjoyment of health (within its holistic definition as guided

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<sup>175</sup> Ibid (n29) 278-279

<sup>176</sup> Ibid (n22) 83

by the WHO Constitution) through access to various health facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health – a good health system (emphasis added).<sup>177</sup>

For instance, the Ministry of Health is alleged to have misappropriated over 32 billion shillings through projects such as the NHIF ‘Linda Mama’ Programme aimed at realizing the executive’s free maternal health services directive, the Medical Equipment Supplies scandal that has since 2015 seen counties receive an array of medical equipment on lease through the national government’s Ministry of Health and the continuous flagrant disregard for the devolution of primary health care functions of county governments as protected and enshrined in the Constitution and regulated by the Inter-Governmental Relations Act.<sup>178</sup>

The aforementioned touches on the realization of the right to RH care and evidences one of the key barriers in the realization of the right to RH care – the missing link between good laws protecting and promoting the dignity of women and girls and the reciprocal enjoyment of these right(s).

Subsequently, it would be pertinent to interrogate the role of marketization and commodification within the health sector. Whilst health is so fundamentally interlinked with the inherent dignity of persons and the consequent respect and protection owed to a human being, recent trends founded on the former continue to prevail in the Kenyan Health System that suffers as highlighted above from poor leadership and governance. The health sector in Kenya relies heavily on foreign ‘investments’ from development partners and aid from other governments. Kenya’s domestic contribution to its own health budget does not reflect its 15% commitment as

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<sup>177</sup> Ibid (n58) para 9

<sup>178</sup> Corruption Tracker <<https://trackcorruption.org/>> accessed on 5 October 2019

guided by the Abuja Declaration.<sup>179</sup> As at the ten year review only eight African Countries were on track with their health budget allocation and spending, Kenya was (and is not) one of them.

Consequently, states are obliged by the ICESCR to take steps maximum of the available resources with a view to progressively realize the right to health and with due regard to this study, the right to RH care. It also gradually alludes to intentional steps and goals to be taken immediately or within a reasonably short period of time.<sup>180</sup> Kenya has not effectively realized this and it is manifestly reflected in the various results within the six pillars of a good health care system as espoused by WHO and compounded by subsisting RH outcomes as highlighted under Chapter three of this study.

## **4.5 RECOMMENDATIONS**

### **4.5.1 Legal and Policy Reforms**

Continuous legal and policy reform cannot and should not be overlooked and overrated. The law is dynamic and cannot be stagnant due to the ever-changing society it seeks to govern and that in turn, seeks to employ it. There are still in existence laws in Kenya that impede the enjoyment of the right to RH care for women that require attention. For example, the continuing injustices propagated to women and health care providers with due regard to the right to access safe and legal abortion. The conflict between Article 26(4) of the Constitution and Sections 158-160, 210, 227 and 228 of the Penal Code of Kenya has resulted in misinformation and subsequent criminalization of abortion even in instances where the Constitution has provided exceptions

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<sup>179</sup> Ibid (n3) 2

<sup>180</sup> CESCR General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) para 33

allowing safe and legal access. Continuous improvement and review of legal and policy reforms should be in tandem with the progressive realization envisaged for the right to RH care.

In addition, laws that relate to reinforcing and ensuring efficiency with due regard to the six pillars of a good health system should be expanded and reviewed to ensure transparency and accountability. This ensures proper budget tracking, accountability and subsequent provision and access of services. Transparency allows for all persons to be able to identify any failure on the part of the state in upholding its legal obligations towards the realization of the right to RH care.

#### **4.5.2 Improved Monitoring in implementation**

Limit setting principles, such as progressive realization of Socio-Economic Rights, within a human rights driven constitutional framework are seen as going against the letter and the spirit of the Bill of Rights, however they might in themselves encapsulate monitoring, evaluation and accountability towards the progressive realization of the right to RH care. In addition, this measuring system in itself should rely on core and fundamental rights and freedoms of the Constitution such as the right to public participation.

Four outstanding or necessary conditions that stand out include: Public involvement and information dissemination where decisions regarding direct and indirect measures could impede the right to RH care. It is pertinent that the rationales behind these decisions are made public thus upholding the citizens' rights to access health information<sup>181</sup> for the enjoyment of their right to RH care as enshrined within the Constitution. Additionally, there must be mechanisms in place to allow the citizenry to interrogate and question any limit setting that the state attempts to rationalize. Essentially, creating a balance between the role of the state and that of Kenyans as

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<sup>181</sup> Ibid (n48) Article 35

active recipients of health services, commodities and treatment for them to enjoy their right to RH care. A proto-type that might help in the analysis and revamping of this recommendation can be employed in the ongoing pilot UHC Program, *Afya Bora Wema wa Kenya* – another growing example of the Kenyan Health System failure to address, among other components, the right to the highest attainable standards of RH care. Only time will tell.

Consequently, improved monitoring on implementation of the right to RH care can be attained through utilising in-country legal and normative frameworks, regional treaty obligations and mechanisms, citizenry driven initiatives and international law applicable to Kenya through treaty monitoring mechanisms.

#### **4.5.3 Public Interest Litigation as a tool for accountability**

The protection and upholding of the right to dignity for every human being continues to be defiled without the proper implementation and realisation of Socio-Economic rights. Subsequently, the judicialisation of these rights in Kenya is leading to the emergence and prominent reliance on public interest litigation, commonly referred to as a last resort. Many non-state actors in collaboration with various Kenyans have sought the court's guidance on violations by the state as a direct or indirect causation from progressive or even regressive implementation of Socio-Economic rights within the Constitution.

Litigation becomes a formidable tool for social accountability as envisaged in this paper's analysis, due to the jurisprudence set by constitutional petitions' judgements that can be enforceable as law and provide an opportunity for interpretation of the law through the basis of the lived experiences of Kenyans. Thus far, it continues to provide relief with due regard to the

realization of the right to RH care and in future, alongside other advocacy programs, may prove to be the solution to ensuring the realization of the right to RH care in its totality.

#### **4.5.4 Expand and Capacity Build County Governments on their Legislative Mandate on the Primary Health Care Function**

With the existence of progressive laws and the evidence in research and data findings that considerable improvement can be recorded, it is evident that a holistic top to bottom approach is necessary to ensure that these laws translate into every Kenyan enjoying and exercising their right to RH care. During the drafting process of the Constitution there were some divergent views as to the inclusion of Socio-Economic rights in the Bill of Rights rendering them as justiciable rights due to the prevailing burden of thought on resource allocation.<sup>182</sup>

Exploring how to reinforce County obligations towards the establishment of County laws on RH care as mandated by the fourth schedule of the Constitution of Kenya could prove a significant complementary role towards the realization of the right to RH care. Already, counties have begun exploring this mandate in a bid to ensure that reproductive justice prevails within their county. One such example is Makueni County which has enacted the Makueni MNCH Act which provides for components of RH Care including the expanding of the parameters of Article 26(4) of the Constitution on when a woman can access safe and legal abortion. Therein, they have included instances of sexual violations and that only the consent of a woman is needed for access in the aforementioned scenario.<sup>183</sup>

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<sup>182</sup> Waruguru Kaguongo, 'Reflections on the Complexities in Adjudicating Socio-Economic Rights from the Perspective of Resource Allocation and Budgetary Issues', in Japhet Biegon and Godfrey M. Musila (eds) *Judicial Enforcement of Socio-Economic Rights Under the Constitution: Challenges and Opportunities for Kenya* (vol. 10 Kenyan Section of the International Commission of Jurists 2011) 89

<sup>183</sup> Makueni MNCH Act, 2015 section 6

#### **4.5.5 The Role of the Court in realizing reproductive justice**

The courts through Constitutional Petitions as highlighted in this research project, can serve as a tool for social accountability and justice. For the most part, it is apparent, whether enforcing the right to health and RH care as of fundamental value or within the auspices of the right to life, the foundation seems to be the right to human dignity. This in itself reinforces the very spirit and essence of all human rights and automatically calls for realization. The courts have proven to interpret the right to health and RH care intrinsically aligned to the normative foundations of human rights.

This adoption of a human rights based approach is a useful tool in guiding the state in the implementation of article 43(1) (a) and even though courts are generally referred to in advocacy as a last measure, their guidance as a separate arm of government can prove useful in the progressive realization of the right to RH care negating the creeping reality of discrimination against women. In addition, mechanisms such as structural interdicts continue to prove useful in measuring compliance of the state in the realization of the right to health. The Ugandan case of *Cehurd v Mulago Hospital*<sup>184</sup> is a good example of how such mechanisms can go a long way in ensuring the progressive realization of the right to health.

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<sup>184</sup> CEHURD v. Mulago National Referral Hospital 212 of (2013) High Court of Uganda at Kampala



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