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Petition 266 of 2015

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

REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA

AT NAIROBI

CONSTITUTIONAL AND HUMAN RIGHTS DIVISION

PETITION NO 266 OF 2015

FEDERATION OF WOMEN LAWYERS (FIDA – KENYA).....1ST PETITIONER

JMM THROUGH PKM

(SUING AS GUARDIAN AND NEXT FRIEND OF JMM).....2ND PETITIONER

RUTH MUMBI MESHACK.....3RD PETITIONER

VICTORIA OTIENO AWUOR.....4TH PETITIONER

AND

THE ATTORNEY GENERAL.....1ST RESPONDENT

THE CABINET SECRETARY, MINISTRY OF HEALTH.....2ND RESPONDENT

THE DIRECTOR OF MEDICAL SERVICES.....3RD RESPONDENT

EAST AFRICA CENTER FOR LAW AND JUSTICE.....1ST INTERESTED PARTY

KENYA CHRISTIAN PROFESSIONALS FORUM.....2ND INTERESTED PARTY

CATHOLIC DOCTORS ASSOCIATION.....3RD INTERESTED PARTY

JOHN MBUGUA.....4TH INTERESTED PARTY

ARTICLE 19 EASTERN AFRICA.....5TH INTERESTED PARTY

PHYSICIANS FOR HUMAN RIGHTS.....6TH INTERESTED PARTY

NAZLIN UMAR RAJPUT.....7TH INTERESTED PARTY

WOMEN'S LINK WORLDWIDE.....1ST AMICUS CURIAE

NATIONAL GENDER AND EQUALITY COMMISSION.....2ND AMICUS CURIAE

KENYA NATIONAL COMMISSION ON HUMAN RIGHTS....3RD AMICUS CURIAE

JUDGMENT

Introduction

The Petition

1. JMM died in June 2018. Born on 5th February 2000, she was just 18 years of age. In January 2014, she had been admitted to form one at [Particulars Withheld] Secondary School, a day school situated within Keumbu Ward in Nyaribari Chache Constituency. She was staying with her elder married sister.

2. At some point in 2014, JMM was forced into sexual intercourse by an older man. She only realized that she was pregnant when she missed her menstrual cycle for two months and started feeling nauseous. She, however, did not disclose this to anyone for fear of being blamed and rejected by the family members.

3. On 8th December 2014 an older girl with whom JMM shared a bedroom introduced her to a person whom they referred to as 'doctor.' The "doctor" advised her that she could terminate the pregnancy. On a Saturday at 6.00 a.m. her roommate took her to a pharmacy situated at Ibeno Trading Centre where the roommate paid Kshs 1,500.00 towards the said procedure. Without examining JMM or carrying out any tests, the 'doctor' directed her to a back room where she was asked to lie on a bed. She was injected on her thigh and advised to go home and wait for the foetus to be expelled the next day.

4. When the foetus was not expelled, JMM returned to the pharmacy and the 'doctor' proceeded to insert a metal-like cold object in her vagina and once again the 'doctor' told JMM to go home as the foetus would be expelled by that evening. That evening, JMM started vomiting and experiencing severe stomach pains accompanied by heavy bleeding. She did not, however, disclose all this to her family, telling them only that she had a headache.

5. This information was narrated to the court by PKM, the 2nd petitioner, mother and next friend of JMM. PKM had received a call on 10th December 2014 from her elder daughter's mother in law, with whom JMM was staying, informing her that JMM was feeling unwell, and was vomiting and bleeding heavily. She requested the said mother in law to take JMM to Ibeno dispensary where, upon being interrogated by the medical staff at the facility, JMM revealed that she had procured an abortion. The dispensary, however, did not have the equipment, facility and skilled staff to assist JMM, so it availed its ambulance to transfer JMM to Kisii Teaching and Referral Hospital, a Level 5 Hospital, approximately 15.6 km away. It was here that PKM found JMM in the afternoon of 10th December 2014 where the medical staff confirmed to her that JMM had procured an unsafe abortion. At the Hospital, JMM was taken to a general ward where the foetus was removed. JMM stayed at the Hospital till 12th December 2014 when she was discharged. PKM was unable to tell the exact nature of treatment that JMM received at the hospital, apart from being placed on intravenous therapy.

6. On the third day of JMM's admission, the staff at Kisii Level 5 Hospital advised PKM that due to the unavailability of dialysis services at the hospital, JMM ought to be transferred to a health facility, which had such services as her kidneys, were failing due to heavy bleeding. She was advised to take JMM to Tenwek Mission Hospital, a faith-based hospital situate in Bomet County, about 50 kilometres from Kisii Town. Accordingly, and upon settling the accrued bill of Kshs 3,500.00 at the Kisii Level 5 Hospital, she made her own private

arrangements to transfer JMM by taxi to Tenwek at the cost of Kshs 3,500.00 as she could not afford the amount of Kshs 12,000.00 required to transfer her by the Kisii Level 5 Hospital ambulance.

7. On 12th December 2014 at about 10.00 a.m., PKM transferred JMM to Tenwek Hospital where they arrived after about one and a half hours of travel. JMM was admitted into the intensive care unit upon payment of Kshs 3,000.00 by PKM. At the time of her admission at Tenwek Hospital, JMM was not able to talk.

8. After three days of treatment, JMM was able to speak. She remained at Tenwek for about 7 days till 19th December 2014 when she was discharged on the ground that Tenwek Hospital did not have any equipment to undertake dialysis. PKM was then advised to take JMM either to Moi Teaching and Referral Hospital, Eldoret or Kenyatta National Hospital. She was offered the Hospital's ambulance to transport JMM upon her undertaking to settle the accrued bills, which at the time of discharge was Kshs 65,000.00.

9. PKM opted to take JMM to Kenyatta National Hospital where they arrived on 19th December 2014. JMM was immediately admitted for surgical treatment. She continued to receive treatment, including dialysis, until 25th February 2015 when she was officially discharged as an inpatient but was to continue receiving treatment as an outpatient. The diagnosis from Kenyatta National Hospital at the time of her discharge was that JMM had had a septic abortion and haemorrhagic shock and had developed chronic kidney disease. As a result, JMM was referred for follow-up in the renal unit of Kenyatta National Hospital.

10. JMM's troubles, however, were far from over. By the time of her discharge, the bill at Kenyatta National Hospital had risen to Kshs 39,500.00 which PKM was unable to pay. As a result, JMM was detained at the Hospital during which period she slept on a mattress spread on the floor due to scarcity of beds. She again fell sick during this period of detention and was once again taken to the main ward where she was treated for about four days. She was then returned to the detention room where she stayed for a period of 2 weeks until her release on 13th March 2015 when the hospital bill was waived.

11. The medical advice that PKM received after JMM's release from hospital was that she was required to undergo dialysis every month at Kenyatta National Hospital renal unit at the cost of Kshs 50,000.00, a sum that was way beyond PKM's reach. However, it would appear that due to financial constraints, JMM was yet to embark on her outpatient dialysis by the time of filing the petition.

12. PKM blames her daughter's predicament on the respondents. She argues that the Government of Kenya, through the **Ministry of Health National Guidelines on the Management of Sexual Violence in Kenya, 2nd Edition, 2009 (2009 National Guidelines)**, made pursuant to section 35 (3) of the Sexual Offences Act, allowed termination of pregnancy as an option in case of pregnancy occurring as a result of rape. It was her case, further, that it is not clear how such services would be accessed. She contends that the physical and mental health of many women and adolescent girls would be protected if information was available with regard to the cadre of health professional that can provide services for legal termination of pregnancy.

13. PKM further argues that the withdrawal by the 3rd respondent of the **2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya (2012 Standards and Guidelines),** and the **National Training Curriculum for the Management of Unintended, Risky and Unplanned Pregnancies (the Training Curriculum)** on 3rd December, 2013 and 24th February 2014 respectively undermines the

right to access safe legal abortion services, therefore leading to women and girls in the position of JMM to secure unsafe abortions from unqualified and untrained persons such as the 'doctor' who procured her abortion on 8th December 2014.

14. PKM's position was supported by the 3rd and 4th petitioners. These petitioners are both community human rights mobilizers residing in Mathare Constituency within Nairobi County. Their area of residence is a mainly informal settlement inhabited by persons of low economic status. They narrate in their affidavits in support of the petition their experiences with cases touching on women and girls' reproductive health, such as early pregnancies, defilement, rape, and unsafe abortion.

15. They noted that a number of young women and girls have been left with disabilities as a result of unsafe abortion. Some of them have died after undergoing unsafe abortions at the hands of unskilled persons within the Mathare community who claim to have the skills and training to undertake abortions. The 3rd and 4th petitioners contend that women and girls in their community choose unsafe methods to terminate their pregnancies due to inability to access trained health workers, sometimes due to lack of information about when abortion is allowed, and sometimes out of fear that the cost of seeking legal abortion services may be beyond their economic means.

16. The 3rd and 4th petitioners' support for the petition is based on their belief that there is need for the government to provide information to the public on the circumstances in which abortion is allowed in Kenya and who can offer legal abortion services.

17. The 3rd petitioner avers that as a community mobiliser, she receives about three to five cases of rape and defilement from her community every week and would like to know if women who fall pregnant following rape incidents are legally entitled to an abortion. From her experience, the persons who offer abortion services to women and girls in the informal settlements such as Mathare lack the necessary skills and knowledge, and they unnecessarily put their lives and health at risk. She avers that there is a need for the Government to have trained health workers to offer this service in their community.

18. The 3rd petitioner's sentiments were echoed by the 4th petitioner, who narrated similar experiences from her work in reproductive health community outreach activities in Mathare and also as a community mobiliser. She had seen cases of young girls who had died from unsafe abortions, or, who had suffered complications in the process of procuring abortions from unskilled persons, and, who, did not seek medical treatment, and had died as a result.

19. The 1st petitioner, Federation of Women Lawyers (FIDA – Kenya) is a non-profit organisation committed to the creation of a society that respects and upholds women's rights. FIDA-Kenya states that it has realised a failure of the justice system due to poor coordination of government response to its own policies with respect to reproductive health rights of women and girls. It notes that this is especially so since the **Sexual Offences Act** already provides that a girl such as JMM, a minor who has been defiled and is therefore a survivor of a sexual offence, is entitled to protection and rehabilitation.

20. It also notes the challenge that the police are having in their attempt to prosecute abortion-related offences under the **Penal Code**. It observes that the prosecutions are done without due consideration to the permitted grounds for access to legal abortion under the 2010 Constitution, and the threats and harassment that medical providers go through in the hands of law enforcement agencies in cases of suspected abortion provision in spite of the constitutional provisions.

21. Like the 2nd petitioner, the 1st petitioner places responsibility for the predicament in which girls like JMM and the poor girls in informal settlements find themselves in on the actions of the 3rd respondent, the Director of Medical Services (DMS), for withdrawing, by his letter dated 3rd December 2013, the **2012 Standards and Guidelines** and the **Training Curriculum**. It contends that the actions of the respondents will exacerbate the already existing confusion within the health and police sectors with regard to legal abortion services. In addition, it states that it unduly isolates and stigmatizes a health service that is not only legal, but only required by women and which may prove to be lifesaving for a number of women.

22. The 5th and 6th interested parties support the position taken by the petitioners. **Article 19 Eastern Africa**, the 5th interested party, is an organisation that works to ensure plurality and diversity in the media. Its goal is to defend freedom of expression and information, and it campaigns to place information at the centre of development policies and practices.

23. The 6th interested party, **Physicians For Human Rights**, is a non-profit organization. Its work around the world focusses on the documentation of human rights abuses with a particular emphasis on the physical and psychological effects on the victims of torture and sexual violence with the aim of providing credible evidence, data and research to corroborate allegations of human rights violations and to prevent future abuses.

The Response

24. The respondents oppose the petition. The 1st respondent is the **Attorney General** of the Republic of Kenya and is sued in his capacity as the principal legal adviser to the government pursuant to the provisions of Article 156 of the Constitution.

25. The 2nd respondent is the **Cabinet Secretary, Ministry of Health** charged with overseeing the Ministry of Health, which is responsible for the development of policies aimed at the provision of high quality and affordable health care for the people of Kenya. The Ministry is also charged with the development of a well-trained and motivated workforce of health professionals with the ability to adequately respond to any public health-related issues and emergencies.

26. The 3rd respondent is the **Director of Medical Services (DMS),** Ministry of Health and the Registrar of the Kenya Medical Practitioners and Dentist Board, the statutory body that regulates the practice of medicine, dentistry, and medical institutions. He is sued pursuant to his role as the coordinator of all technical functions of the Ministry of Health and as the principal adviser to the Cabinet Secretary responsible for Health.

27. The 1st, 2nd, 3rd and 7th interested parties also oppose the petition and support the position taken by the respondents. This position is that the 3rd respondent rightly withdrew the **2012 Standards and Guidelines** and the **Training Curriculum**.

28. The 1st interested party, the **East Africa Center for Law and Justice**, describes itself as a non-profit organization whose main aim is to become a credible and reliable source of information for members of society on matters relating to policy enactment and legislation.

29. The 2nd interested party is the **Kenya Christian Professionals Forum**. It describes itself as an organisation that brings together Christian professionals engaged and making meaningful contribution in different sectors of the economy. Its main objective is to campaign for the consideration of the perspectives and ideas held by Christian professionals in Kenya and by extension, all other Christians in policy formulation and public debate on topical and sensitive issues.

30. The 3rd interested party is the **Catholic Doctors Association**. Its stated objective is to promote high professional standards in the practice of medicine and dentistry, ethically respecting all human life from conception to natural death.

31. **Ms. Nazlin Umar Rajput**, the 7th interested party, is an advocate of women's rights and the rights of the unborn child.

32. Three organisations were joined to the petition as *Amici Curiae*. The first *Amicus* is **Women's Link Worldwide,** an organization that uses the power of the law to promote social change that advances the human rights of women and girls, especially those facing multiple inequalities.

33. The 2nd *Amicus* is the **National Gender and Equality Commission**, a constitutional commission established pursuant to Article 59(4) and (5) of the Constitution with the overall mandate of promoting gender equality and freedom from discrimination in accordance with Article 27 of the Constitution. The 3rd *Amicus Curiae* is the **Kenya National Commission on Human Rights** which is established under Article 59(1) of the Constitution. It has the constitutional mandate to promote, respect, protect and observe human rights and to develop a culture of human rights in Kenya.

The Dispute

34. In September 2012, the Ministry of Medical Services, pursuant to a consultative process, issued the 2012 Standards and Guidelines and the Training Curriculum. However, by a letter dated 3rd December 2013 (Ref. No. MOH/CIR/2/1/2), the DMS withdrew both the 2012 Standards and Guidelines and the Training Curriculum.

35. Thereafter, by a memo dated 24th February 2014 (Ref. No. MOH/ADM/1/1/2 directed to **"All Health Workers – Public/Private/FBO [Faith Based Organizations]"** and entitled **"Training on Safe Abortions and Use of Medabon (Mifepristone + Misoprostol) for Abortions" (the Memo),** the DMS directed all those to whom it was addressed not to participate in any training on safe abortion and use of Medabon. It stated that anybody attending the trainings or using the drug Medabon would be subjected to appropriate legal and professional proceedings. The DMS went on to state in the said Memo that ***"the 2010 Constitution of Kenya clearly provides that abortion on demand is illegal and as such there was no need to train health care workers on safe abortion or importation of medicines for medical abortion."***

36. It is these actions and pronouncements of the DMS that are at the centre of this petition. The petitioners argue that the DMS had no power to unilaterally and arbitrarily withdraw the 2012 Standards and Guidelines and the Training Curriculum; that the withdrawal left a gap and exposed JMM and others in her position to a denial of, *inter alia,* their reproductive health rights.

37. The respondents counter that the withdrawal was justified. The DMS had received information that some members of Kenya Obstetrical and Gynaecological Society (KOGS), a registered association of professional Obstetricians and Gynaecologists in Kenya, and its stakeholders were training health care workers on safe abortion practices and the use of Medabon, to procure abortions; and that abortion on demand is prohibited under Article 26 of the Constitution.

The Petitioners' Case.

38. The petitioners' grievance revolves around the letter dated 3rd December 2013 withdrawing the 2012 Standards and Guidelines and the Training Curriculum and the Memo dated 24th February 2014. As earlier mentioned, the Memo stated that the office of the DMS had received information that some members of KOGS and its stakeholders were training health care workers on safe abortion and the use of Medabon medicine for abortion. It directed all health workers (public/private/FBO) not to participate in any training on safe abortion and use of Medabon. It warned that anybody attending any such training or using Medabon would be subjected to appropriate legal and professional proceedings. Medabon is a combination pack of Mifepristone and Misoprostol (also known in medical circles as Mife and Miso respectively), both of which are part of the World Health Organization (WHO) recommended medicines for inducing abortion.

39. The petitioners argue that the DMS's actions in withdrawing the 2012 Standards and Guidelines and the Training Curriculum were arrived at arbitrarily and without justification. This is because the withdrawal was grounded on the DMS's assertion that there was no need to train health care workers on safe abortion or importation of medicines for medical abortion since the Constitution clearly provides that abortion on demand is illegal. Additionally, the Memo stated that patients and clients who require care and management for unplanned, unintended, and risky pregnancies would be provided with the necessary and appropriate high quality care that is within the law to prevent morbidity and mortality that may be associated with such pregnancies.

40. The petitioners argue that the Memo was unclear on how appropriate high quality care can be obtained without training healthcare workers and providing an enabling policy framework. They contended that the Memo was sent out notwithstanding that the Kenya Government, in line with WHO Standards, has registered and listed Mife and Miso under the Kenya Essential Medicines List for 2010. Additionally, the petitioners stated that WHO defines essential medicines as those that satisfy the priority health care needs of the population.

41. The petitioners further stated that the Constitution provides grounds under which abortion is permitted in Article 26(4). In the petitioners' view, the law permits abortion in certain circumstances. Further, they argue that the DMS's actions are unlawful, irrational, and unreasonable as they disregard the existence of a comparable policy in the **2009 National Guidelines.** The said Guidelines provide that:

> ***"If they [survivors of sexual violence] present with a pregnancy, which they feel is a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006). If the woman decides to opt for termination, she should be treated with compassion, and referred appropriately."***

42. The petitioners allege that the effect of the withdrawals complained of creates an environment where survivors of sexual violence cannot access safe quality services in reality. They state that the 2012 Standards and Guidelines and the Training Curriculum were developed, approved and published in September 2012 following a participatory engagement involving multiple stakeholders, yet they were withdrawn arbitrarily without reference to them. The petitioners note that the DMS had stated that in his opinion, even though the two documents were meant to standardize and improve the knowledge and skills of health care workers to prevent and manage complications associated with abortion and miscarriage, it had become clear that they were not being used for the intended purpose. However, they contend, there was no such evidence.

43. The petitioners further note that by a letter dated 24th February 2014, reference number MOH/ADM/1/1/2, addressed to the Chairperson of KOGS, the DMS reprimanded KOGS over purported research and training on safe abortion and for purportedly developing a policy document and a training curriculum on safe abortion. Further, they contend that the DMS alleged that he had received information that during the 38th KOGS Annual Scientific Conference, held between 19-21 February 2014, sixty percent of the conference was dedicated to the discussions on safe abortion, which the Ministry of Health did not approve of.

44. It was the petitioners' case that the above letters, Memos and or Notices issued by the DMS, were made without prior notice to the affected persons or parties, thus contravening Article 47 of the Constitution, which demands that a written notice of an adverse decision be given, with reasons therein, to the affected person(s).

45. It is the petitioners' argument that according to data from the Kenya National Bureau of Statistics (KBS), Kenya has a high maternal mortality rate at 488 deaths per 100,000 live births, which is far higher than the mortality rate of 175, or less that Kenya had committed to achieve by 2015, in fulfilment of its obligations in connection with the Millennium Development Goals (MDGs), the eight goals that all 191 United Nations member states, including Kenya, agreed in September 2000 to achieve by the year 2015. The said goals commit governments to reduce maternal mortality by 75% as well as combat poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women.

46. The petitioners further state that a May 2012 WHO report identifies Kenya as one of the countries that have made "insufficient progress" towards improving maternal health and meeting MDG's. Further, that at 6,300 (2%), Kenya is one of the ten countries that contributed to 58% of the global maternal deaths reported in 2013 **(WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank and UN Population Division Report).** They also state that unsafe abortion is one of the main causes of maternal mortality in the country with an estimate of 266 women dying per 100,000 unsafe abortions.

47. The petitioners further cited the key findings of a national study on the magnitude of unsafe abortion titled **"Incidence and Complications of Unsafe Abortion in Kenya"** published by the Ministry of Health in 2013. The report estimated that 464,690 induced abortions occurred in Kenya in 2012, corresponding to an induced abortion rate of 48 abortions per 1,000 women, which is higher than the 2002 rate (45/1000), the 2008 average rate for East Africa (39/1000), and the 2008 rate for Africa (29/1000). They also averred that an estimated 119,912 women received care for complications from unsafe abortions such as organ or systems failure, shock and in some instances, these complications lead to death. Further, the study also found that women aged less than 25 years represented 48% of those presenting for post abortion care, likely after unsafe abortion; whereas 17% were women aged 10-19 years old.

48. They further contended that the high level of unsafe abortion, and its impact on the incidence of maternal mortality in Kenya formed a part of the focus of a national public inquiry that was concluded by the Kenya National Commission on Human Rights (KNCHR) in 2012, whose published report recommended that "[t]he Ministry of Health and other stakeholders do develop standards and guidelines to operationalize lawful termination of pregnancy as provided in the Constitution and in line with international human rights frameworks that Kenya is a party to."

49. According to the petitioners, under the Maputo Plan of Action adopted at the Special Session of the African Union Conference of Ministers of Health in Maputo, Mozambique in September 2006, Kenya committed to reduce incidence of unsafe abortion in the country through strategies such as the training of service providers on the provision of comprehensive abortion care services and on the prevention and management of unsafe abortion.

50. It is the petitioners' case that their rights, as founded not only in specific constitutional provisions but also in regional and international human rights instruments, have been violated and/or threatened by the actions of the 2nd respondent and the DMS. It is their contention that the actions of the respondents are in contravention of Articles 2(1), (5) & (6) of the Constitution which allow for applicability of international law in Kenya upon ratification as well as the express provisions of Articles 1 (1), (2), (3) & (4); 3 (1); 10 (1) & (2) (a) & (b); 19; and 47 (1) of the Constitution.

51. The petitioners further pleaded that the **African Charter on Human and Peoples' Rights (Banjul Charter)**; the **African Charter on Human and Peoples' Rights on the Rights of Women in Africa** (**Maputo Protocol**); the **African Charter on Rights and Welfare of the Child (African Children's Charter)**; the **International Covenant on Economic, Social and Cultural Rights (ICESCR)**; the **International Covenant on Civil and Political Rights (ICCPR)**; the **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW**); the **Convention on the Rights of the Child**; and the **Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)** have all been ratified by Kenya. However, the respondents have either ignored or chosen to disregard these Conventions and decided to act arbitrarily and unlawfully in the face of the growing problem of unsafe abortion in Kenya.

52. The petitioners argue that as a result of the foregoing, the DMS's directives impose a disproportionate burden on survivors of sexual violence by conditioning permitted abortion services upon finding a trained health professional from an already extremely limited pool of providers. As a result, he recklessly endangered **JMM**'s life by creating an environment where she could not realistically access safe abortion services.

53. The 3rd petitioner, **Ruth Mumbi Meshack**, swore an affidavit dated 26th June 2015. She averred that she is a community human rights mobilizer and that her work involved sensitizing women and young girls on their rights. Additionally, she averred that she refers those whose rights have been violated to appropriate organs such as government departments, health facilities, and other non-governmental organizations (NGOs) that assist with, among other things, legal and medical interventions and counselling. She also averred that she documents human rights violations within Mathare Constituency, which she shares with NGOs such as FIDA-Kenya, and the Kenya Human Rights Commission (KHRC) to enable them to respond to the needs of the community living in Mathare.

54. She further averred that through her work as a community mobilizer in Mathare Constituency, a mainly informal settlement inhabited by persons of low economic status, she has come across many cases touching on women's and girls' reproductive health. Such cases, she averred, include early pregnancies, defilement, rape, and unsafe abortion. She averred that a number of women, especially young girls, are left with disabilities as a result of unsafe abortion. She further deposes that some have died after undergoing unsafe abortions at the hands of unskilled persons within the Mathare community who claim to have the skills and training to undertake abortions. She expressed her concern that women and girls in her community choose unsafe methods to terminate pregnancies due to inability to access trained

health workers and sometimes due to lack of information on when abortion is allowed and due to fear that the cost of seeking legal abortion services may be costly and therefore beyond their economic means.

55. She further averred that she has witnessed the community mistreat pregnant women and girls by verbally attacking them—asking them questions such as "*nani alikupeleka kutafuta mimba*" ("who took you to look for the pregnancy") and "*si ulipanuwa mapaja kwa raha*" ("didn't you open your legs yourself with a lot of happiness"), causing them untold suffering and stigma.

56. The 3rd petitioner deposed that sometime in 2010, she visited a friend at Mathare who was bedridden for about two weeks and was unable to access medical services for want of funds. She averred that a foul smell emanating from her body had engulfed her small room. She further deposed that her friend divulged to her that her friend had directed her to a woman living within the Mathare community who assisted her to terminate her pregnancy by inserting a sharp object in her vagina and that she thereafter started bleeding profusely.

57. She further deposed that sometimes in 2014, she witnessed a young girl being arrested by the then Officer Commanding Pangani Police Station and members of the community at Kiamaiko in Mathare for allegedly procuring an abortion. The young girl was frog marched (roughly seized and forcefully propelled forward) by the public to the police van while still bleeding, without any concern for her health and in the full glare of the media that had been invited by the public to capture the unfolding story. The public hurled abuse at the young girl and physically assaulted her, which was promptly beamed on television by the media houses. The young girl was later taken to Muthaiga Police Station, and eventually charged in court for procuring an abortion.

58. The 3rd Petitioner followed her to Muthaiga Police Station and requested the Police to allow her to speak to her and upon realizing that the girl's guardian could not afford to take up the services of a lawyer to represent her. She sought legal assistance for her from an NGO through which she was able to obtain the bail amount set by the court. She stated that the girl's case made her realize the challenges faced by women and girls from lower socio-economic backgrounds when they are arrested on suspicion of procuring illegal abortions since they do not have information about the circumstances when the law would permit abortion or where they could access legal abortion services. She averred that the young girl stayed in police custody for about three days before she was taken to a hospital for check-up and was eventually arraigned in court. It was her deposition that such a case demonstrated the need for the government to provide information to the public on the circumstances under which abortion is allowed in Kenya and who can offer legal abortion services.

59. The 3rd petitioner deposed that as a community mobilizer, she receives about three to five cases of rape and defilement from her community every week and would like to know if women who fall pregnant following rape incidents are legally entitled to an abortion. She averred that from her experience, the persons who offer abortions to women and girls in the informal settlements such as Mathare lack the skills and knowledge to conduct abortions and are unnecessarily putting the lives and health of women at risk. She further averred that there is need for the government to have health workers who are trained to offer this service in her community. Additionally, Mathare has many private clinics in comparison to the two public health clinics managed by the government and residents are not aware if the health professionals in the clinics have the requisite training and, therefore, are capable of providing safe and legal abortions, and whether these clinics are licensed to provide abortion services, which affects the decision to seek safe abortion services.

60. She also averred that from her experience of young women losing their lives or living with long-term disabilities because of unsafe abortion, she believes that women who qualify for abortion within the law should have access to safe services and should not have to die or live with lifelong disabilities as a result of seeking services from unskilled persons. Accordingly, she sought this court's clarification on the circumstances under which women can legally access safe abortion services in Kenya.

61. In her affidavit sworn on 26th June 2015, the 4th petitioner, **Victoria Atieno Awuor**, a resident of Mabatini Ward, deposed that she was born and raised in Mathare Constituency, where she engaged in the business of selling fruits and vegetables. She averred that she was also involved in reproductive health community outreach activities in Mathare and served as a community mobilizer and women's rights defender. She further deposed that she was trained on human rights, especially women's rights, by FIDA-Kenya. She deposed that her experiences were similar to those of the 3rd petitioner, save that sometime in 2011, she participated in a radio programmes dubbed ***"Chanuka Dada"*** whose main focus was the creation of awareness around women's rights and giving a voice to the challenges that women and girls experience in Mathare. In the radio programme, girls discussed the challenges they faced in their daily lives, which included early marriages, rape cases, drug abuse, child labour, unsafe sex, unsafe abortions, prostitution, and unemployment. One of the most profound outcomes of the *Chanuka Dada* programmes was the realisation that many women and girls go through unsafe abortion because of the perception that abortion is entirely illegal in Kenya.

62. The 4th petitioner further averred that sometimes in 2014, she noticed a large crowd of people flocking a clinic by the name 'Partners Medical Clinic' in Mathare Constituency. The people were demanding that the owner of the clinic be arrested. In the middle of the floor of the clinic, she saw the lifeless body of a girl who had allegedly died after an unsafe abortion. The crowd was demanding to know how the girl had died and if the clinic had a license to operate. The owner of the clinic took advantage of the commotion and fled before the arrival of the police.

63. It was her deposition that in December 2014, she visited a girl in Mabatini Ward in Mathare who was suspected to have procured an unsafe abortion which led to prolonged bleeding and complications which left her paralyzed on one side of her body. During her visit, the young girl's sister narrated that the girl had procured the services from a local woman popularly referred to as a "midwife" who inserted a knitting needle and drinking straw in her uterus through her vagina. The "mid wife" regularly offered abortion services in her house to women from the community but no one knew if she had any medical training or not. She advised the family to take the girl to seek medical intervention, but they did not do so immediately. After a few days she was informed that the girl had died.

64. The 4th petitioner believed that a number of women in Mathare have needlessly lost their lives or are suffering lifelong injuries that they could have prevented with accurate information and ability to access reproductive health services. She too sought clarification on the circumstances under which women can legally access safe abortion services in Kenya.

65. **Christine Ochieng**, the Executive Director of FIDA-Kenya, made various depositions regarding the FIDA-Kenya's role in these proceedings. In her affidavit sworn on 26th June 2015, she deposed that from 2011 to 2012, in partnership with the Ministry of Health, National Nurses Association of Kenya, and Population Council, FIDA-Kenya launched a campaign dubbed **"Heshima Project: Promoting Dignified Care in Child Birth"** in pilot counties focusing on women's experiences of disrespect and abuse while accessing health

care services. Later, in 2014, the team undertook research aimed at designing, testing, and evaluating an approach to significantly reduce disrespect and abuse of women during labour and delivery in Kenyan health facilities.

66. She averred that FIDA-Kenya monitors compliance by the Kenyan government with its international obligations under various treaties on a number of issues including reproductive health freedom. FIDA-Kenya further seeks to foster the principle that proper support namely universal access to quality health services is a right, without which the full range of women's rights cannot be achieved. She averred that through its provision of free Legal services, FIDA-Kenya represents women who meet a specified criteria for violation of or threat of violation of their rights and has represented women in cases of property rights, custody and maintenance of children, sexual violence, and defence of women charged with certain criminal offences including those charged with illegally procuring abortions, among other cases.

67. She also deposed that through its legal services, FIDA-Kenya receives an average of 60 women every day for three days a week, about 18% of whom present with reproductive health rights issues of which approximately 13% are represented in court and the rest referred to other relevant institutions for further assistance. FIDA-Kenya provides legal support to health service providers who are often arrested or harassed by the police as they go about their duties in ensuring that women's reproductive and maternal health rights are respected and upheld.

68. Ms. Ochieng deposed that FIDA-Kenya engages in public interest litigation in instances where there is a lacuna in the law or where the law is deficient in realizing women's rights. In its commitment towards advocating for human rights, FIDA-Kenya undertakes research on a wide variety of issues including maternal health and works with other stakeholders and the government to ensure that women's rights in general are respected and upheld.

69. Further, she averred that one of the cases she has undertaken, was that of a 17-year old girl who had been arrested and charged with the offence of "conspiracy to commit a felony known as abortion." She contended that such cases epitomize a failure of the justice system due to poor coordination of government response to its own policies especially since the **Sexual Offences Act** already provides that such a girl who has been defiled and is a minor and a survivor of a sexual offence is entitled to protection and rehabilitation. She further stated that sometimes around March 2014, FIDA-Kenya learnt about **Criminal Case No. 536 of 2013** at Kilifi Magistrates Court in which a health provider had been charged with attempting to procure an abortion contrary to section 158 of the Penal Code. The particulars of the offence were that the provider had unlawfully administered the drug Miso to a woman. She observes that such cases typify the challenges faced by the police in their attempt to prosecute abortion-related offences under the Penal Code without due consideration to the permitted grounds for access to legal abortion under the Constitution. It was also her deposition that FIDA-Kenya had noted the threats and harassment that medical providers go through at the hands of law enforcement agencies in cases of suspected abortion provision in spite of the constitutional provisions on abortion.

70. According to Ms. Ochieng, as part of FIDA-Kenya's mandate to monitor women's rights and analyse trends in women rights violations across Kenya, FIDA-Kenya collected and analysed media reports on the problem of unsafe abortion and incidents of rape and defilement between the period August 2014 to March 2015. Its analysis exposed a consistent narrative of underage girls who have suffered defilement, and were exposed to and were dying from unsafe abortion for lack of safe services. She deposed that the girls dying from

unsafe abortion were either from rural areas, or poor socio economic background and in many cases, the unsafe procedure was carried out by known quacks raising serious concerns that not only are women, health care providers, and police unaware of the scope of legally permitted abortion but that the government is also not doing enough to eliminate unskilled abortion providers.

71. Ms. Ochieng further averred that by overwhelmingly voting for the 2010 Constitution, Kenyans had acknowledged that unsafe abortion is a serious issue in the country, hence the need to address the same by providing circumstances under which abortion is permitted in Kenya, and, information on who is qualified to provide abortion services as stipulated under Article 26(4) of the Constitution. She deposed that lack of standards and guidelines and training of health care workers on abortion services continues despite statistics that Kenya's abortion rate is at 48 per 1,000 women of reproductive age (15-49) which compares to a global abortion rate of 28 per 1,000 women and a rate of 29 per 1,000 women in Africa in 2008. She deposed further that in 2012, nearly 120,000 women in Kenya received care for complications resulting from unsafe abortions.

72. Ms. Ochieng deposed that FIDA-Kenya has been invited on many occasions to train the Kenya Police on gender-based violence. It had also discussed with the police a range of issues including sexual violence and the permitted grounds for abortion at which it has been noted that one of the major challenges that the police face is the lack of clarity as to when abortion is permitted and how to identify when the law has been broken with respect to provision of abortion services.

73. It was Ms. Ochieng's deposition that FIDA-Kenya was concerned that the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum, will exacerbate the already existing confusion within the health and police sectors with regard to legal abortion services. The withdrawal will also unduly isolate and stigmatize a health service that is not only legal but also one that is needed only by women, and which may prove to be lifesaving for a number of women.

74. She asserted that the withdrawal heralds the death knell to an important health service that is already difficult to access especially for poor women, adolescents, and women in rural areas who cannot access alternative services from private providers. FIDA-Kenya was concerned that the Memo and the letter dated 3rd December 2013 show the Ministry of Health's determination to unconstitutionally restrict access to legal abortion services in flagrant disregard to Article 26 (4) of the Constitution. FIDA-Kenya was apprehensive that the Ministry's actions will only serve to increase the number of deaths from unsafe abortions as well as the number of women having to live with lifelong disabilities as a result of unsafe abortion.

75. It was her view that the directive not to attend any training on abortion recklessly endangers women's lives by promoting an environment with a limited number of informed and skilled health providers with regard to abortion, a situation which is further alarming especially because the Constitution solely vests access to legal abortion services on the opinion of trained health professionals. By prohibiting training of health care providers, the government policy progressively increases the number of maternal mortalities due to unsafe abortions while progressively reducing the number of trained medical providers, which undermines the position already taken by the government.

76. FIDA-Kenya was of the view that the withdrawal of the 2012 Standards and Guidelines and subsequent directive in the Memo creates fear amongst health care workers resulting in their hesitation in taking appropriate and timely decisions on whether to provide or not to

provide safe and legal abortion services to their clients. The directives also create uncertainty as to the scope of legal grounds for abortion provided under Article 26(4) of the Constitution which confusion is evidenced by the public response to provision of legal abortion services. This confusion is demonstrated by the letter of the Chairman of the University of Nairobi Students Association seeking permission to burn all clinics performing abortions in Nairobi. FIDA-Kenya was aware of a process initiated by the Ministry of Health in 2015 to draft a new set of policies, standards, and guidelines for reducing maternal morbidity and mortality. However, it was apprehensive that there currently exists no structures within the Ministry to guarantee that even if the guidelines were to be adopted, they would not be arbitrarily withdrawn in a similar manner.

77. She expressed the apprehension held by FIDA-Kenya that there is uncertainty regarding the finalization and adoption of any new standards and guidelines, and whether the content of these standards and guidelines will be aligned to the 2010 Constitution. Whereas the Ministry of Health has taken more than one and a half years without addressing the confusion it has created within the health sector by its directives, women have continued to suffer preventable deaths.

78. Ms. Ochieng made reference to a report compiled and launched in 2013 by the Ministry of Health, African Population and Health Research Center (APHRC), IPAS, and Guttmacher Institute, in which the Ministry of Health acknowledged that ***"one missing link in reducing maternal mortality has been the absence of technical and policy guidelines for preventing and managing unsafe abortions to the extent allowed by the Kenyan law,"*** and further, that the continued stigmatization of abortion services makes such services unavailable, leading to poor outcomes, especially for poor and rural-based women who end up dying; whereas affluent women are able to access safe abortion services privately.

79. She noted that the Ministry of Health, in its **National Reproductive Health Training Plan (2007-2012) (NRHTP)** stated that the mission of the health sector in Kenya is to promote and participate in the provision of integrated and high quality curative, preventive, and rehabilitative health care service. That the Plan further notes that for the Ministry of Health to describe health care workers as skilled attendants, more investment must be made in competency-based training both during pre-service and in-service to ensure proficiency in reproductive health skills. It is her averment that the in-service courses in reproductive health listed in the NRHTP do not include a specific course on comprehensive abortion care, and the Ministry does not conduct in-service comprehensive abortion care trainings to fill the gap in the pre-service trainings for health care workers.

80. FIDA-Kenya took the position that under the Maputo Plan of Action, Kenya has committed to reduce incidence of unsafe abortion through strategies such as the training of service providers in the provision of comprehensive abortion care services and in the prevention and management of unsafe abortion. On the other hand, WHO, through its **"Safe Abortion: Technical and Policy Guidance for Health Systems**" has recommended that actions to strengthen policies and services related to abortion should be based on the health needs and human rights of women and a thorough understanding of the service-delivery system and the broader social, cultural, political, and economic context. WHO has defined unsafe abortion as ***"termination of an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both."*** Safe abortion, she stated, is the termination of an unwanted pregnancy by a health provider with the requisite skills and in an appropriate medical environment.

81. She referred to the 2010 WHO technical opinion to **Action Canada for Population and Development**, which stated, among other things, that abortions performed in a context of poor availability of quality services are likely to be unsafe. She also stated that WHO reiterated the key actions adopted by the 21st Special Session of the United Nations General Assembly for further implementation of the ICPD Programme of Action, which noted that, in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take measures to ensure that such abortion is safe and accessible.

82. Ms. Ochieng further averred that in 2002, FIDA-Kenya, together with Kenya Medical Association and IPAS, conducted research and produced a publication titled "**Reproductive Rights in Kenya: From Reality to Action."** One of the key recommendations to the government was to adopt comprehensive reproductive health services including those relating to abortion, and that health workers at all levels should be trained on high quality, safe techniques of termination of pregnancy and post abortion care services.

83. FIDA-Kenya together with the Center for Reproductive Rights (the Center), published a book entitled "**Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities,"** one of whose key findings was that unsafe abortion is rampant in Kenya and is a great risk to public health. A key recommendation of the publication to the government of Kenya was to facilitate the provision of continuous training for reproductive health care providers who provide post abortion treatment in both public and private practice.

84. FIDA-Kenya also referred to a nationwide public inquiry by KNHRC on reproductive rights violations of women seeking health care services in public facilities in 2011, whose findings expressed concerns that maternal health policies in Kenya had failed to pay sufficient attention to complications arising from unsafe abortion. The study recommended that the government develops standards and guidelines to operationalize lawful termination of pregnancy, and ensure that the constitutional provisions on abortion are taught in all health training schools.

85. She referred to the Ministry of Health's 2009 National Guidelines but doubted that the Guidelines are known and therefore do not translate into practical benefits for survivors of sexual violence. Judging by the un-procedural withdrawal of the 2012 Standards and Guidelines, FIDA-Kenya was apprehensive that the 2009 National Guidelines are also exposed to potential arbitrary withdrawal. She noted in a further affidavit sworn on 8th October 2015, that the window for termination of pregnancy given to victims of sexual violence by the 2009 National Guidelines had been closed by 2014 guidelines which blurred the lines as to the legality of termination of pregnancy resulting from an act of rape.

86. FIDA-Kenya's took the position that the DMS's prohibition of health care workers from participating in any training on safe abortion violates the constitutional guarantees of the right to the highest attainable standard of health, which includes the right to reproductive health care. Further, that by prohibiting health care workers from participating in trainings on safe abortion services, the DMS is restricting the accessibility and availability of safe abortion services as well as affecting the quality of such services.

87. She stated that the DMS's prohibition of health care workers from participating in any training on safe abortion, and use of Medabon and the warning that those who attend these trainings, or use Medabon will face legal and professional proceedings, creates uncertainty regarding the legality, and use of Mife and Miso, which are both registered as essential medicines in Kenya in accordance with WHO standards. In FIDA-Kenya's view, the DMS's prohibition of training on safe abortion and the withdrawal of the 2012 Standards and

Guidelines and the National Training Curriculum violate women's and adolescent girls' right to access comprehensive, accurate, and evidence-based health-related information and forces them to resort to inaccurate information through informal sources.

88. She averred that it was FIDA-Kenya's view that the assertion in the Memo by the DMS, that there is no need to train health care workers on safe abortion, and the prohibition of health care workers from participating in any training on safe abortion, and use of Medabon negatively affects the provision of safe abortion, a medical procedure that only females need. The withdrawal has a negative impact on women's and adolescent girls' wellbeing since it sustains and potentially increases their exposure to health risks not experienced by men. Further, it has a disproportionate effect on poor and rural women as it negatively affects the availability of these services and the geographical distribution in the country.

89. It was her case that the DMS's actions contravenes the state's obligation to ensure the right to life, and increases women's exposure to the risk of life-threatening injury and death from unsafe abortion performed by untrained health care workers. The DMS's actions also impede the protection of their health and safety, thereby violating their constitutionally guaranteed consumer rights and the right to enjoy the benefits of scientific progress.

90. It was therefore contended that the prohibitions in the Memo are overbroad in scope and application and violate Article 24(1) of the Constitution. FIDA-Kenya was concerned that a great amount of national resources has been employed in researching and developing the Standards and Guidelines and it is irresponsible and an abuse of power to arbitrarily withdraw it without consultation and public participation.

91. In further support of their case, the petitioners relied on the affidavit sworn by **Prof. Joseph Gatheru Karanja**, a full professor in Obstetrics and Gynaecology in the University of Nairobi where he also taught between 1994 and 2000. He is a member of the KMA, KOGS and several other local and international professional bodies. It was his evidence that he has a thorough understanding of the medical curriculum both at the degree and at the diploma level in Kenya, Uganda and Tanzania. Further, that, through trainings organized by non-governmental organizations and professional associations, such as the KOGS, he has trained mid-level providers on aspects of comprehensive abortion care in an attempt to translate various research findings into practice which trainings have included post-abortion care (PAC) for middle-level health workers to enhance access to PAC by women in under-served areas, prevention and management of obstetrical fistula, and comprehensive abortion care trainings.

92. Prof. Joseph Karanja stated that he was actively involved in the Kenya constitutional review process from 2004 until the promulgation of the Constitution in 2010 and he is a founding member of the National Reproductive Health Steering Committee for organizations that were interested in engaging with the constitutional review process. It was this Steering Committee, which gave birth to the Reproductive Health and Rights Alliance (RHRA), an alliance of health organizations and associations working on reducing maternal mortality due to unsafe abortion. Through the RHRA, he presented views to the Constitutional Review Committee in regard to the drafting of the language around the right to health and access to legal abortion, which greatly informed the current Article 26 of the Constitution.

93. Between 2011 and 2012, he was a member of the task force set up by the Ministry of Health to draft the 2012 Standards and Guidelines. Prof. Joseph Karanja stated that the need to develop the 2012 Standards and Guidelines arose from the fact that so many women were needlessly dying as a result of unsafe abortion despite the provisions of Article 26(4) of the Constitution. In his view, the objective of the 2012 Standards and Guidelines was to have a

government policy guideline on the prevention and management of unsafe abortion within the circumstances allowed under Article 26(4) as a key link for reducing maternal mortality and morbidity and to increase access to safe legal services in order to reduce unsafe abortions. It was therefore his view that with the adoption of the 2012 Standards and Guidelines, organizations such as KOGS, whose objectives include encouragement of high standards of practice in the art and science of Obstetrics and Gynaecology in order to attain the best possible level of health for women and children in Kenya, would use them as a basis for training medical professionals on safe legal abortion skills. According to Prof Karanja, KOGS gets approval and accreditation of continuous professional development for providers from the Kenya Medical Practitioners and Dentists Board (KMPDB), which is a professional body charged with the mandate to regulate the practice of medicine and dentistry under Chapter 253 of the Laws of Kenya.

94. According to Professor Joseph Karanja, the 2012 Standards and Guidelines provided an avenue for training of health professionals and provided consistency of care for women by relying on evidence-based medical practices to improve the quality of services. He noted that the DMS had withdrawn the 2012 Standards and Guidelines, without consultation with those who participated in the process of developing them. In his view the withdrawal of the 2012 Standards and Guidelines and the letter dated 24th February 2014 to KOGS had the negative impact of denying health workers accurate information and skills through training and promoted a state of confusion surrounding the interpretation and implementation of Article 26(4) of the Constitution.

95. According to Professor Joseph Karanja, the Memo dated 24th February 2014 from the DMS sent a contradictory message on the Ministry of Health's stand on reducing unsafe abortion as a public health concern. On the one hand, the Ministry acknowledges through several of its documents and in its foreword to the now withdrawn Standards and Guidelines that unsafe abortion constitutes 30% of maternal mortality and therefore every effort should be put in place to reduce these figures. Yet, on the other hand, it prohibited the participation of any health worker in any training that would help reduce these figures.

96. He averred that from his experience as a Professor at the University of Nairobi and his work with various medical training colleges, he had noted the training gaps that exist in the pre-service and in-service training of health professionals, especially the inadequate knowledge of laws and regulations related to abortion and inadequate knowledge and skills in provision of safe abortion services. While the training of medical doctors addresses abortion care services, the training of nurses and clinical officers at the medical training institutions does not. Yet, the Constitution has authorized mid-level providers such as nurses and clinical officers to provide safe legal abortion services. He asserted that the training of health care providers is one of the key determinants to the provision of safe health services including safe legal abortion services in any country.

97. Professor Joseph Karanja averred that the costs of treating medical complications from unsafe abortion constitute a significant financial burden on public health care systems in the developing world. In Kenya 119,912 women were treated for unsafe abortion in 2012, according to a study conducted by the APHRC and the Ministry of Health, which demonstrates the strenuous impact of unsafe abortion on the health care systems by significantly diverting the already scarce resources to an easily preventable public health problem. Further, that although there are no recent studies, a study by KMA, FIDA-Kenya and IPAS in 2004 conservatively estimated that the total annual direct cost for treating incomplete abortions presenting to public hospitals was approximately Kenya shillings 18.4 million.

98. It was his position that the continued stigmatization of abortion services creates unavailability of safe abortion services and leads to poor outcomes especially for poor and rural-based women who largely suffer denial of legal abortion services and end up dying; whereas affluent women are able to access safe abortion services privately. Based on his own knowledge and information from the **WHO Safe Abortion: Technical and Policy Guidance for Health Systems (Second Edition),** it is an accepted best practice to opt for a medical rather than surgical abortion approach when dealing with early pregnancy up until the 12th week. To his knowledge, the medicines registered and available in Kenya for the provision of medical abortion are Mife and Miso, and Medabon is a brand name of these two medicines combined.

99. He contended that the withdrawal of the 2012 Standards and Guidelines and the Memo foster confusion among health service providers, with the resultant effect of the health care providers' hesitation to take appropriate and timely decisions on whether to provide or not to provide safe legal abortion services to their clients. He opined that it is inconceivable, and, imprudent for the Ministry of Health to prohibit members of KOGS, and other technically-equipped stakeholders within the country to offer training on safe abortion to health care providers who still lack the specific training, and, who are also in need of continuous development in the arena of safe abortion, especially because the Ministry is not offering these trainings, yet the Constitution requires that only trained health professionals shall perform these services.

100. Professor Joseph Karanja stated that it is recommended by **WHO Safe Abortion: Technical and Policy Guidance for Health Systems, (Second Edition),** that termination of pregnancy by competent health service providers who have adequate skills, and within facilities that meet the minimum medical standards is safe, complications are rare, and thus, where safe abortion services are available, and of good quality, abortion-related complications and death are low. Further, that in his foreword to a study conducted by the APHRC and the Ministry of Health, released in August 2013, the DMS stated that evidence from the study drives home the importance of training to adequately equip health providers with the requisite skills and knowledge to provide quality abortion–related care to women. Further, the study, which was based on data from a nationally representative sample of both public and private sector hospitals and health facilities, found that nearly 465,000 induced abortions occurred in Kenya in 2012. The Ministry of Health and APHRC study further highlighted the need to implement standards and guidelines on reducing unsafe abortion, extend abortion care training to mid-level providers and to promote the use of medical abortion throughout the country, which would provide benefits to women.

101. He further observed that the 2012 Standards and Guidelines not only touch on provision of safe legal abortion services but also on post abortion care which is non-controversial and is acknowledged as critical treatment that the government of Kenya should make available to patients in need in all cases. To this end the Ministry of Health has developed the **National Post Abortion Care Reference Manual (2013)** and the **National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya (2014)**. It was his position that the government has a responsibility to provide comprehensive post abortion care service, hence the importance of the Standards and Guidelines. Even in instances where legal abortion is not available to a patient, the government still has a responsibility to provide quality comprehensive post abortion care to all patients in need. He disclosed that the Community info pack at annex 13 of the **National Health Sector Standard Operating**

Procedures on Management of Sexual violence in Kenya of 2014 lists ***"Access termination of pregnancy and post abortion care in the event of pregnancy from rape"*** among the rights of a survivor of sexual violence.

102. Based on the review of the statements of **PKM** on the care given to **JMM**, and upon reviewing the confidential medical report by **Prof. S O Mc'Ligeyo**, **Prof Joseph Karanja** was of the professional view that had **JMM** received timely quality post abortion care, she would not have suffered the serious kidney problems, which she developed. In his view, the requisite quality post abortion care is only possible if the Ministry of Health gives the necessary training to mid-level service providers on abortion and post abortion care.

103. The Petitioners also relied on the affidavit by **Prof. Japheth Kimanzi Mati** sworn on 26th June 2015. Prof. Mati was the Chairman of the Department of Obstetrics & Gynaecology, University of Nairobi, Kenya, from 1975 to 1986 and the Dean of the Faculty of Medicine from 1981 to 1984. He is a specialist in Obstetrics and Gynaecology in the Universities of Nairobi, Glasgow and London. He is a Fellow of the Royal College of Obstetricians and Gynaecologists (FRCOG) in London. He practiced Obstetrics and Gynaecology and Reproductive Health since 1966 and retired from active practice in 2009. He is a consultant and continues to engage in policy advocacy-related work in the area of his expertise.

104. Prof Mati averred that the need to develop standards and guidelines arose from the fact that so many women were needlessly dying or having to live with medical conditions suffered as a result of unsafe abortion despite the provisions of Article 26(4). The Ministry of Health had, in recognition of the problem, began a multi-sectoral process to develop such standards and guidelines culminating in the adoption of the 2012 Standards and Guidelines. The objective of the 2012 Standards and Guidelines was to standardize quality of practice in the prevention and management of unsafe abortion, which remained largely unclear despite the 2010 constitutional provisions giving grounds for legally accessing abortion services.

105. In his opinion, the 2012 Standards and Guidelines offered an excellent compendium of critical information that any health professional would need for the proper and safe management of abortion, and the appendices provided comprehensive coverage of the main issues, practices, and skills, which are related to all aspects of abortion management. Prof Mati stated that from his own knowledge and information, upon the adoption of the 2012 Standards and Guidelines, organizations such as KOGS had used them as a basis for training medical professionals on the relevant skills and procedures required to provide safe abortion in line with the constitutionally permitted grounds.

106. It was his view that the continued lack of access to legal safe abortion services has caused women to resort to illegal, unsafe abortions often resulting in maternal deaths or the women being subjected to lifelong disabilities as a consequence of the unsafe procedures. Further, that the 2012 Standards and Guidelines had specified the circumstances under which abortion could be legally provided. This included the type of facility that could carry out terminations, a guide for persons allowed to provide termination of pregnancy, a guide for situations where pregnancy poses a danger to the life or health of the pregnant woman, and a guide for conscientious objection by health professionals. They also provided an avenue for training of health professionals and provided consistency of care for women by relying on evidence-based medicine to improve the quality of medical decisions and thus reassured health professionals on the quality of services they provided.

107. Like Prof. Joseph Karanja, Prof. Mati was of the view that the withdrawal of the 2012 Standards and Guidelines has the negative impact of denying health workers accurate information and skills through training. He however disclosed that in 2014, the Ministry of Health established a Technical Working Group which he chaired to develop new standards and guidelines. The work was ongoing. From his experience, health practitioners across the country need guidelines which present to them all angles in the management of abortion, including their outcomes, whether positive or negative, so as to enable them make informed decisions on which modes of treatment to apply in managing abortion, especially in light of Article 26(4) which vests the judgment on whether to provide or not to provide abortion solely in trained health professionals.

108. Prof. Mati also agreed with Prof. Joseph Karanja that the Ministry of Health has acknowledged that unsafe abortion is a serious public health issue. It contributes to maternal mortality and morbidity, and the continued stigmatization of abortion services makes such services unavailable, leading to poor outcomes, especially for poor and rural-based women who end up dying, whereas affluent women are able to access safe abortion services privately. He disclosed that the Ministry of Health coordinates pre-service training through the various statutes under which health professionals are trained and is responsible for setting standards and guidelines for reproductive health training and service provision and ensuring that the standards are well adhered to.

109. He stated that Ministry of Health institutions including the Medical Training Colleges do not provide pre-service training on comprehensive abortion care. It is only doctors whose training includes both theoretical and practical training on abortion. He noted that the dilemma is that doctors are few in rural and low-income areas of Kenya, which leaves the provision of reproductive health services largely in the hands of mid-level health care workers.

110. According to Prof Mati, the Ministry of Health in its **National Reproductive Health Training Plan (2007-2012) (NRHTP)** stated that the mission of the health sector in Kenya is to promote and participate in the provision of integrated and high quality curative, preventive and rehabilitative health care service. It notes that for the Ministry of Health to describe health care workers as skilled attendants, more investment must be made in competency-based training both during pre-service and in-service to ensure proficiency in reproductive health skills. However, the list of in-service courses in reproductive health listed in the NRHTP does not include a specific course on comprehensive abortion care and the Ministry does not conduct in-service comprehensive abortion care trainings to fill the gap in the pre-service trainings for health care workers.

111. He was also aware of the Memo from the DMS prohibiting health workers from participating in any training on safe abortion and use of Medabon medicine brand for medical abortion. However, it was his view that under the Maputo Plan of Action Kenya has committed to reduce incidences of unsafe abortion through strategies such as the training of service providers in the provision of comprehensive abortion care services and in the prevention and management of unsafe abortion. He agreed with Prof Joseph Karanja that it is an accepted best practice to opt for medical rather than surgical abortion approach when dealing with early pregnancy up until the 12^{th} week. His view is that the only medicines registered and available in Kenya for medical abortion are Mife and Miso whose combined brand name is Medabon. It was his view that the Memo by the DMS paints a negative image of the medicines, which may have the net effect of pharmacists not stocking and selling them. The effect would be that they would not be available which would endanger the lives and health of women.

112. Prof Mati further deposed that he was aware, based on his own knowledge and information accessed from the ***WHO Safe Abortion: Technical and Policy Guidance for Health Systems (Second Edition)***,that WHO recommends that actions to strengthen policies and services related to abortion should be based on the health needs and human rights of women. There should be a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context. He stated that unsafe abortion is a major contributor to the unacceptably high levels of maternal morbidity and mortality prevailing in Kenya, especially amongst poor and marginalised communities.

113. It was therefore his opinion that the training of health service providers is a key intervention in the prevention of unsafe abortion and the attendant complications and that training of health professionals should have two broad objectives. First, to familiarize them with the legal provisions under which circumstances termination of pregnancy is lawful, and, second, to provide competency in the various aspects of provision of safe abortion services, including clinical judgement and skills. He opined that training of abortion providers must ensure that they have the competencies to provide good-quality care in accordance with national standards and guidelines.

114. Prof Mati stated that he was a member of the panel in the **Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya** undertaken by the KNCHR in 2011 whose findings and recommendations were alluded to by FIDA-Kenya.

115. It was further his view that lack of policy guidelines on prevention and management of unsafe abortion and the subsequent prohibition of training on provision of safe abortion prevent access to new scientific knowledge. Further, it denies women's access to quality reproductive health care. He therefore believed that reinstatement of the 2012 Standards and Guidelines is in the best interest of the public to safeguard the rights and safety of women pending the reproduction of any set of new guidelines.

116. The Petitioners therefore prayed for:

> ***A. A declaration that the right to the highest attainable standard of health, right to non-discrimination, right to life, right to be free from cruel, inhuman, and degrading treatment, right to freedom and security of the person, right to information, consumer rights, and right to benefit from scientific progress of the 2nd, 3rd, and 4th Petitioners as women of reproductive age and other women and adolescent girls of reproductive age whose interest they represent has been violated and/or threatened by the 3rd Respondent's letter of 3 December 2013, reference number MOH/CIR/2/1/2, and Memo dated 24 February 2014, reference number MOH/ADM/1/1/2.***
>
> ***B. A declaration that the right to freedom of expression, freedom of conscience, freedom of association, the right to assembly, the right to information, the right to benefit from scientific progress, and the right to equal protection of the law of health care workers in Kenya has been violated and/or threatened by the 3rd Respondent's letter of 3 December 2013, reference number MOH/CIR/2/1/2, and Memo dated 24 February 2014, reference number MOH/ADM/1/1/2.***
>
> ***C. An order quashing the 3rd Respondent's letter dated 3 December 2013, reference number MOH/CIR/2/1/2, a2nd the Memo dated 24 February 2014, reference number MOH/ADM/1/1/2, for being unlawful, illegal, arbitrary, unconstituti2onal, and thus null and void ab initio.***

D. An order reinstating and disseminating the 2012 standards and guidelines in their original form and permanently prohibiting the Ministry of Health from taking retrogressive measures that undermine access to legal abortion services and post abortion care as provided for under the Constitution.

E. An order restraining the respondents or their representatives and or agents in any manner whatsoever from restricting the training of health professionals, threatening and or intimidating health care professionals with punitive measures or prohibiting them from obtaining any instructions, teaching, or learning about safe legal abortion and post abortion care through their professional organizations or training institutions.

F. A declaration that the right to the highest attainable standard of health, including reproductive health care services protected in Article 43(1)(a) of the Constitution, entitles victims of sexual violence to abortion in situations where, in the opinion of a trained health professional, continuing with a pregnancy would endanger the life or health of the victim as envisaged in Article 26(4) of the Constitution.

G. An order against the respondents to make comprehensive reparations to JMM which include damages for violations of her rights and physical and emotional harm suffered, provide comprehensive free healthcare services for all the medical needs of JMM that have arisen because of the violations occasioned to her, and undertake measures to guarantee non-repetition.

H. An order for all parties to bear their own costs of the suit, because the petition is brought in the public interest.

I. Any other or further orders that the Honourable Court may deem fit to grant.

The 5th Interested Party's Case

117. The position adopted by the petitioners was supported by the 5th interested party, **Article 19 Eastern Africa**. Its case was that the right to information relating to sexual and reproductive rights is clearly set out in international law as an essential element of the right to health and countries have an obligation to ensure that information about sexual and reproductive health is available to all individuals and groups.

118. It contends that the right to information is crucial to the right to health in three respects. First, individuals need to have access to reliable and accurate health information, including about risks to general public health. Second, that individuals must have access to reliable and accessible information held by health professionals about their own health. Third, access to information is essential for individuals and groups, as well as human rights monitors to be able to scrutinize the state's implementation of its obligations on the right to health.

119. After setting out provisions of various international instruments, the 5th interested party cited Article 2 (5) and (6) of the Constitution and contended that Kenya is bound by the above instruments. According to the 5th interested party, the effect of the Memos by the DMS was that it limited Kenyans freedom to seek, receive and impart information and ideas, including academic freedom and freedom of scientific research as enshrined in Article 33 of the Constitution. The memo also limited the right of citizens to access information on medicines and treatments available for safe emergency abortion treatments and primarily affected the ability of trained healthcare providers to train and gain knowledge on the use of Medabon for purposes of providing safe abortion services in line with Article 26(4) as well as girls and women's ability to procure emergency abortion treatment during pregnancy. It

contended that while Article 24 (1) requires that any limitations to rights or fundamental freedoms must be provided by law, the DMS's action of withdrawing the two drugs is not founded on any statutory authority whatsoever. On the contrary, this power lies solely with the Pharmacy and Poisons Board established under section 43(1) of the **Pharmacy and Poisons Act (CAP 244)** which provides that:

> ***"The Minister, on the recommendation of the Board, may by order, prohibit or control the manufacture, sale, advertisement or possession of any secret, patent, proprietary or homoeopathic medicine, preparation or appliance."***

120. To the 5th interested party, in as much as the DMS is the Chairperson of the Pharmacy and Poisons Board by dint of section 3 of the establishing Act, the decision to withdraw any drug or poison is the province of the Minister of Health, upon recommendation of the Board as a collective resolution. Consequently, it was contended that the Memo issued by the DMS has no force of law because the DMS did not possess the power to remove or classify medicines and in this respect the 5th interested party relied on the case of **Pastoli vs. Kabale District Local Government Council and Others [2008] 2 EA 300**.

121. It was further contended that the Memo by the DMS is also manifestly misguided in so far as it does not abide by Article 24 (2) requirements. The DMS in his Memo did not elaborate on the limitation to Articles 33 and 35 rights and did not show why, and how long and the nature of the limitation of these rights. Instead, the Memo strangely proclaimed, *"abortion on demand was illegal in Kenya"* and conveniently neglected to mention Article 26(4). Accordingly, the contents of the Memo, as the instrument that limited the right to seek, receive and impart information, did not satisfy Article 24 (2) (a) (b) and (c) requirements.

122. Moreover, Article 24 (3) expressly shifts the burden to justify proposed limitation to a fundamental right to the State or person seeking to limit such right. The 5th interested party contended that in this petition, the burden lies with the respondents, being the state agencies best placed (now burdened) by the Constitution to justify the limitations imposed on freedom of expression by the DMS's Memo. For this proposition, the 5th interested party relied on **R vs. Oakes [1986] 1 SCR 103**. It argued that it is moreover noteworthy that the respondents have failed or elected not to justify the limitations as required of them by Article 24 (3) by failing to show the necessity of the limitation with regard to the nature of the right.

123. The 5th interested party further contended that the Memo unjustifiably limits the right to seek, receive or impart information so much so as to derogate the right itself contrary to Article 24(2). If medical practitioners cannot train, on pain of unspecified sanction or professional proceedings by the DMS, then the purpose and nature of the right to seek receive and impart information and ideas as protected by Article 33 of the Constitution and the right to academic freedom and freedom of scientific research is essentially defeated. In the same breath, if girls, women and the general public are denied the right to access information about legitimate treatment options, then the right to information under Article 35 of the Constitution stands defeated.

124. It was therefore submitted that in light of the above, the limitation of the right to freedom of expression and the right to access information occasioned by the DMS's Memo is unjustified as per Articles 33, 35 and 24 of the Constitution and thus should be declared so. Since the restrictions do not meet the criteria set out in Article 24 of the Constitution, the DMS's actions were not supported by law, not prescribed by law, not pursuing a legitimate aim and not necessary nor proportionate in an open and democratic society.

6th Interested Party's Case

125. The petition was supported by the 6th interested party, **Physicians for Human Rights**, through an affidavit sworn by its Country Coordinator, **Christine Alai**. She deposed that the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum and the directive banning all health care workers from participating in any training on safe abortion and use of Medabon, created an atmosphere where young girls like **JMM,** and women who suffer from sexual violence are unable to freely and safely access services for termination of pregnancies resulting from rape and defilement. It contends that the said decision is fundamentally flawed; it breaches basic rights and freedoms enshrined in the Constitution and goes against express provisions of the Constitution and the law. This is so due to the fact that the Constitution in Article 26(4) provides for the right to safe abortion in emergency treatment situations; if the life or health of the mother is in danger; or if permitted by any other written law.

126. According to the 6th interested party, the Constitution in the same Article vests the discretion to determine instances when safe abortions can be procured on two entities being trained health professionals; and Parliament through legislation. In the 6th interested party's view, Article 26(4) requires health professionals to be trained in order to be in a position to exercise and apply their expert opinions on whether an emergency treatment requires the procurement of an abortion, or the life or health of the mother is in danger. To the 6th interested party, Article 43(1) (a) of the Constitution is closely linked to Article 26(4) because it protects the right of every person to the highest attainable standard of health, which include the right to health care services, including reproductive health care. Article 43(2) further provides that a person shall not be denied emergency medical treatment.

127. The 6th interested party relied on the Preamble to the Constitution, and the definition of health by WHO which is ***"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*** It contended that the said definition was adopted and expanded in the **International Conference on Population and Development (ICPD) Programme of Action of 1994**, which define reproductive health as ***"a state of complete 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."*** The ICPD Programme of Action further provides that this definition implies that **"people are able to have a satisfying and safe sex life,"** ***"the capability to reproduce and the freedom to decide if, when and how often to do so"***, and ***"the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."***

128. It was therefore the 6th interested party's position that the right to reproductive health care consists of measures aimed at ensuring that women and girls can fully exercise and enjoy their right to freely reproduce and make decisions regarding reproduction, including the right not to have a pregnancy imposed upon them through sexual violence. In this respect, the Kenya affirms women and girls right to reproductive health care, including the right to make decisions regarding reproduction free of violence, through various laws and policies. The **Sexual Offences Act of 2006** (**SOA**) prohibits various forms of sexual violence including rape, defilement and incest while section 35 thereof and the **Sexual Offences (Medical Treatment) Regulations of 2012** provide for free medical treatment for victims of sexual offences.

129. In this regard, the Ministry of Health has promulgated National Guidelines on Management of Sexual Violence in Kenya, first published in 2005, second edition in 2009 and the current and third edition having been revised in 2014 (hereafter the **2014 Guidelines**) which outline the process of clinical management of sexual violence.

130. In the event that a survivor falls pregnant as a result of sexual violence, the 2014 Guidelines provide: **"if a survivor intends to terminate a pregnancy which resulted from the sexual violence, the health care provider and the survivor should be aware of the Constitutional provision in reference to abortion, thus 'abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other law (Kenya Constitution 2010)'**.

131. The 6th interested party stated that the **GBV Community Awareness Info Pack** in Annex 11 of the 2014 Guidelines explicitly provides that survivors of sexual violence have a right to ***"access termination of pregnancy and post abortion care in the event of pregnancy from rape,"*** a wording maintained from the 2009 edition of the **National Guidelines.**

132. According to the 6th interested party, by providing survivors of sexual violence with access to termination of pregnancy services, the 2009 National Guidelines contemplate that there are a myriad of factors that may make it difficult for survivors to access Emergency Contraceptives (EC) within 120 hours, or at all, following an incident of rape or defilement. Numerous reports world over have documented these factors, including survivors fear of stigmatization by their communities or reprisal by perpetrators; structural factors such as lack of financial resources to cater for transportation and cost of medical services, long distances to health facilities, and sometimes unavailability of EC and other appropriate post-rape care and treatment in health facilities, especially in rural and remote settings; and lack of awareness or information among communities on their legal rights to access medical treatment and the nature of available post-rape care and services.

133. The 6th Interested Party referred to a study recently conducted in Kenya, Liberia, Sierra Leone and Uganda by University of California, Berkeley School of Law Human Rights Center, titled ***The Long Road: Accountability for Sexual Violence in Conflict and Post-Conflict Settings,*** and its own study titled ***Time Series Analysis of Sexual Assault Case Characteristics and the 2007-2008 Period of Post-Election Violence in Kenya*** between 2012 and 2013. It contended that the studies revealed that while EC is provided in Kenyan law as part of the minimum package of post-rape care, in reality, many victims of sexual violence are unable to access EC within 120 hours or at all and are exposed to the risk of conceiving unwanted pregnancies. Moreover, although EC is known to be highly effective in prevention of pregnancy, WHO has reported that certain forms of EC pills may be less effective if taken after 72 hours.

134. The 6th interested party averred that the 2009 National Guidelines rightly recognize that the protection afforded to survivors of sexual violence for prevention of unwanted pregnancies cannot cease with the provision of EC. In its view survivors have a right to comprehensive reproductive health care that includes the ability to access services for termination of pregnancies in the event that they conceive as a result of rape or defilement.

135. It echoed the submissions of the petitioner and 5th Interested Party that the withdrawal of the 2012 Standards and Guidelines has created confusion and apprehension among health care workers and survivors of sexual violence on their entitlement to access services for termination of pregnancies resulting from rape and defilement.

136. These survivors are faced with the hard choice of resorting to unsafe means to get rid of unwanted pregnancies with dire consequences to their health and lives. In the alternative, victims of sexual violence are condemned to carry unwanted pregnancies to term, with

detrimental effects on their health and socio-economic status as reflected in a Human Rights Watch report published in February 2016, titled ***"I Just Sit and Wait to Die: Reparations for Survivors of Kenya's 2007-2008 Post-Election Sexual Violence***".

137. It was further contended that the withdrawal of the Training Curriculum and the issuance of the Memo prohibiting all health care workers from participating in any training on safe abortion and use of Medabon denies survivors of sexual violence access to the highest quality of reproductive health care services attainable by skilled health care professionals. In addition, the 2014 directive by the DMS banning the use of Medabon hampers the availability of high quality medicines for termination of pregnancy services.

138. According to the 6th interested party, the DMS' ban on the use of Mife and Miso is illegal and contrary to section 43 of the **Pharmacy and Poisons Act** and Rule 8 of the **Pharmacy and Poisons (Registration of Drugs) Rules** which vest the responsibility of authorizing the use, ban, and distribution of drugs on the Cabinet Secretary and the Pharmacy and Poisons Board and not the DMS.

139. It was further contended that the DMS' directive banning training on safe abortion and use of Medabon therefore denies health care workers and survivors of sexual violence their right to enjoy benefits of scientific progress, including research and application of research findings and that the DMS withdrawal of the 2012 Standards and Guidelines means that health care professionals have no guidance to assist them in arriving at an appropriate determination on provision of termination of pregnancy services.

140. Further, the absence of clear standards means that clinicians are unable to exercise their discretion on provision of termination of pregnancy services in a predictable and standardized manner. This inevitably affects the availability of clear information and creation of awareness among the citizenry on the nature of post-rape care services available to victims of sexual violence. The DMS' threat of legal and professional proceedings against any health care worker who would attend training on safe abortion and use of Medabon has created fear and apprehension among health care professionals to freely exercise their discretion as envisaged in Article 26(4) of the Constitution.

141. In addition, the withdrawal by the DMS of the 2012 Standards and Guidelines, and the Training Curriculum, and the directive banning training of health care workers on safe abortion and use of Medabon, is unlawful, irrational and unreasonable and is not within the limitations envisaged in Article 24 of the Constitution. This is because first the DMS purports to withdraw a right that is inherent in every human being, and, protected in the Constitution and the 2009 National Guidelines; second, he offers no rationale or justification for the withdrawal of Medabon; third, he offers no alternative that is less restrictive, intrusive, costly and harmful; and lastly, the attempt to withdraw protection already afforded to survivors of sexual violence in the law is retrogressive, contrary to the cardinal principle of progressive realization of the right to health, including reproductive health.

142. According to the 6th interested party, the failure by the DMS to put in place new standards and guidelines and a training curriculum, occasions ongoing challenges and violations to many victims of sexual offences and health care workers. The 2014 Guidelines envisage that nurses and clinical officers, may, in addition to medical practitioners, offer the necessary medical treatment to victims of sexual violence. As such, training must be focused on equipping nurses and clinical officers with relevant knowledge and skills, and enhancing theirs, as well as medical practitioners' knowledge and skills over time based on emerging scientific developments.

143. It was the view of the 6th interested party that the act of the DMS of withdrawing trainings for health care workers on safe abortions and the use of Medabon breaches the right to fair administrative action and equal benefit and protection of the law. In its view, forcing victims of sexual violence to carry the consequences of their violation to term through an unwanted pregnancy may occasion mental instability, trauma and psychological torture to the victims. It was contended that victims of sexual violence should not be made to suffer twice through compulsion to carry to term pregnancies that are the consequence of offences, which are prohibited under Kenyan penal law in particular sections 3, 8, 10, 20 and 21 of the **Sexual Offences Act**, **2006** which explicitly prohibit rape, defilement and incest.

144. It is therefore an indictment of the criminal justice system to condemn the victim of a crime to carry a pregnancy resulting from the offence to term, even when it poses a challenge to her health and wellbeing, yet there is no other known criminal offence in Kenya where victims of the offences are compelled to bear the burden of the consequences of the crime they have suffered.

145. While not advocating for blanket abortion in all instances of pregnancies resulting from rape, defilement and incest, the 6th interested party explained that it seeks to secure the protection of the right of women and girls to make a choice whether or not to keep such a pregnancy, without fear, coercion or discrimination.

146. The 6th interested party relied on **R vs. Big M Drug Mart Limited [1985] 1 SCR 295,** cited in **Marilyn Muthoni Kamuru & 2 Others vs. Attorney General & Another [2016] eKLR** for the principle that the interpretation of the Constitution must be done in a purposive manner in order to give life and meaning to its provisions.

147. According to the 6th interested party, the burden of the Court is to construe the provisions in a manner that indeed promotes the interests of those for whom it was enshrined and for this position they relied on the decision of the Supreme Court in the **Matter of the Principal of Gender Representation in the National Assembly and the Senate Advisory Opinion No. 2 of 2012 [2012] eKLR.**

148. According to the 6th Interested Party, while Article 26(1) of the Constitution guarantees the right to life, Article 26(4), permits abortion in three instances: if in the opinion of a trained health professional there is need for emergency treatment; or the life or health of the mother is in danger; or if permitted by any other law. However, despite the affirmation in the **2009 National Guidelines,** the DMS's withdrawal of the 2012 Standards and Guidelines has created confusion and apprehension among health care workers and survivors of sexual violence on their entitlement to access services for termination of pregnancies resulting from rape and defilement.

149. It was submitted that since the right to health is enshrined in Article 43 (1) (a) and in this case is integral to giving life to the provisions of Article 26 (4), by virtue of the provisions of Article 2(6), the international treaties and conventions which Kenya has ratified form part of the laws of Kenya. The 6th interested party relied on **Walter Osapiri Barasa vs. Cabinet Secretary Ministry Of Interior And National Co-Ordination & 6 others, Constitutional Petition 488 of 2013** and **Mary Rono vs. Jane and William Rono, Court of Appeal at Eldoret, Civil Appeal 66 of 2002.**

150. According to the 6th interested party, WHO in the Preamble to its Constitution defines health as a state of complete, physical, mental, and social well-being and not merely the absence of disease or infirmity which definition has since been adopted by Kenyan law by dint of the **Health Act, 2017**. Similarly, the **General Comment No. 14** of the Committee on Economic, Social and Cultural Rights at Paragraph 1 states that health is a fundamental

human right indispensable for the exercise of other human rights and every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. This commentary further states that 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 WHO or the adoption of specific legal instruments in the various member States.

151. It was averred that the International Conference on Population and Development Program of Action 1994 (hereafter "Program of Action") adopted and expanded the definition of health to include reproductive health as a key element of the right to the highest attainable standard of health

152. It was further submitted that the right to the highest attainable standard of health and reproductive health and its inextricable link to the enjoyment of all other rights is a well-established principle of law that is given due regard world over and should as such be given due regard by this Honourable Court and indeed by the respondents in the instant petition. The 6th interested party observed that the Program of Action lays out at Principle 8 the guiding principle that States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health, and that reproductive health care programmes should provide the widest range of services without any form of coercion.

153. According to the 6th interested party, violence against women is a widespread cause of physical and psychological harm or suffering among women, as well as a violation of their right to health. Consequently, the **Committee on the Elimination of Discrimination against Women** in its recommendations adopted after its 11th General Session in 1992 requires States to, among other things, enact and enforce laws and policies that protect women and girls from violence and abuse and provide for appropriate physical and mental health services. Health-care workers should also be trained to detect and manage the health consequences of violence against women, while female genital mutilation should be prohibited. They referred to the definition of sexual violence in the WHO's, **World Report on Violence and Health.** Reference was made to the case of **C. K. (suing through Ripples International as her guardian & next friend) & 11 others vs. Commissioner of Police/Inspector General of the National Police Service & 3 Others (2013) eKLR,** which, it was submitted, recognised the profound effect of sexual violence on the health of the victims.

154. It was submitted that victims of sexual violence suffer tremendous effects on their health and therefore fall within the ambit provided at Article 26 (4) of the Constitution. It was further submitted that WHO in 2003 promulgated the **Guidelines for Medico-Legal Care of Victims of Sexual Violence** which guidelines take cognisance of the consequences that sexual violence may have on the victim including, physiological and psychological trauma. Further, the role of the medical practitioner in providing services that are needed include pregnancy testing, abortion services (where legal), STI testing and/or prophylaxis, treatment of injuries and psychosocial counselling.

155. The 6th interested party submitted that victims of sexual abuse may suffer from a number of physical, emotional and psychological injuries, profoundly impacting all aspects of their lives. When sexual assault results in a pregnancy, the harm experienced may be exponentially exacerbated; particularly, in countries with restrictive abortion laws, where such pregnancies leave women with the dire choice between carrying the pregnancy to term or undergoing a clandestine, unsafe abortion.

156. It was contended that the effect of sexual violence on the health of a mother is envisioned in the provisions of Article 26(4) as being a danger to the health of a mother. Sexual violence survivors are well documented to have effects on their mental and physical health that puts their lives at risk. A significant risk to the health of the mother is suffered particularly as a result of the pregnancy acquired due to the sexual violence suffered by the victim. This documentation, according to the 6th interested party, appears in the WHO Report on Sexual Violence which reveals some of the effects on the health of a victim to include a range of psychological consequences, both in the immediate period after the assault and over the longer term.

157. These include guilt, anger, anxiety, depression, post-traumatic stress disorder, sexual dysfunction, somatic complaints, sleep disturbances, withdrawal from relationships and attempted suicide. Accordingly, the well-documented effects of sexual violence on the health of a victim include direct effects on their health and could eventually have an adverse effect on their lives as well. This places a survivor of sexual violence within the purview of the provisions of Article 26(4), which envisions that abortion is permitted where the health of a mother is in danger. In the instance of sexual violence as hereinabove illustrated, the health of a mother is exponentially in danger and especially where the pregnancy is contracted as a result of the sexual violence.

158. According to the 6th interested party, this is further buttressed by the provisions of the Program of Action and its definition of health. The definition encompasses both the physical and mental well-being of the person.

159. Further, the WHO Guidelines recognise that there exists a gap in numerous countries on the health care needs of victims of sexual violence and the health services available to the said victims. It recommends treatment guidelines or protocols which serve a number of valuable functions as follows: In the case of the management of victims of sexual violence, guidelines can help national health systems improve the quality of treatment and support provided to victims of sexual violence; secondly, standard protocols can guide the process of forensic evidence collection; and thirdly, they can be a useful educational tool for health care professionals seeking to increase their capacity to provide an adequate level of care.

160. The 6th interested party therefore submitted that in keeping with its mandate to ensure the citizens' rights are fully recognised and enjoyed, the State has heretofore recognised the role of violence in deterring the realisation of the right to health especially amongst women and this is seen in the enactment of the **Sexual Offences Act, 2006** at Section 35 which provides for the medical treatment of survivors of sexual offences. This is accentuated by the enactment of the **Sexual Offences (Medical Treatment) Regulations of 2012**, which provide for the rights of a survivor of a sexual offence to access free medical treatment. Further, the Regulations provide that a medical practitioner may conduct a full medical-forensic examination on a victim of a sexual offence and thereafter recommend the appropriate medical treatment.

161. According to the 6th interested party, the DMS in issuing the Memo violated Article 47 which guarantees every citizen the right to administrative action that is expeditious, efficient, lawful, reasonable and procedurally fair. According to the 6th interested party, the limitations to the right life are explicitly set out in the Constitution and any action by the respondents to further limit the said right is unconstitutional and thereby null and void.

162. With regard to the issue whether the State has met its obligation in ensuring the right to the highest attainable standard of health is realised, the 6th interested party relied on the Advisory Opinion of the Supreme Court in the **Matter of the Principal of Gender**

Representation in the National Assembly and the Senate Advisory Opinion No. 2 of 2012 [2012]eKLR and the decision of the Constitutional Court of South Africa in the case of **R vs. Grootboom CCT 11/00** on the question of progressive realisation of rights. They further cited Article 12 of the **ICESCR** on the duty of the States Parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. They also relied on **Luco Njagi & 21 Others vs. Ministry of Health & 2 Others [2015] eKLR** where the Court affirmed the provisions of the **International Convention on Economic, Social and Cultural Rights** on the obligation of the State to ensure access to medical care and attention.

163. Further reliance was placed on Paragraph 12 of the **General Comment No. 14** by the **Committee on Economic Social and Cultural Rights**, as regards the various components of the right to the highest attainable standard of health which includes availability, quality and accessibility of trained and skilled medical and professional personnel.

164. In conclusion, it was the 6th interested party's case that pregnancy conceived as a result of sexual violence affects women's rights to reproductive health care, which includes the right to freely determine when to conceive without use of force, coercion or violence. Article 43(1) of the Constitution, which protects the right of women to reproductive health care, thereby necessitates the provision of comprehensive measures to ensure that women fully enjoy their right to reproductive health care, including prevention of and/or access to termination of pregnancies resulting from sexual violence particularly rape and defilement.

165. It was contended that the withdrawal of Medabon while insisting that high quality services will be provided leaves only surgical options, which are only available in higher-level facilities, therefore making services economically and geographically inaccessible to majority of survivors of sexual violence; and denying survivors availability of high quality medicines. Further, the directive banning the use of Medabon in all health facilities (public, private and FBOs) hampers the availability of high quality medicines for termination of pregnancy services.

166. In the circumstances, the court was urged to allow the petition and grant the orders sought therein as prayed.

The Respondents' Case

167. The respondents opposed the Petition. They relied on a replying affidavit sworn on 20th August 2015 by **Dr. Nicholas Muraguri,** the then DMS. Dr. Gondi Odhiambo, the Head of the Reproductive and Maternal Health Services Unit at the Ministry of Health adopted his affidavit. According to Dr. Gondi, the Unit falls under the Division of Family Health, and he is the custodian of the technical arm of the Ministry that coordinates policy, standards and guidelines, quality of care and technical support on maternal reproductive health services in Kenya.

168. In his affidavit, Dr. Nicholas Muraguri, stated that the goal of reducing maternal morbidity and mortality is part of the Millennium Development Goals and Kenya has achieved the least progress towards the realization of this goal. Accordingly, tackling unsafe abortion is key to the country's attainment of the said goals, whose achievement will also reduce the costs of health care.

169. It was in this light that the Ministry released the 2012 Guidelines. The Guidelines, according to Dr. Muraguri, were meant to address a gap in one of the major causes of maternal mortality in Kenya – unsafe abortions, as well as to address and control the illness and other complications that normally arise from unsafe abortions. He confirmed that the

Guidelines were withdrawn on 3rd December 2013 following disagreement amongst the stakeholders, including different faiths, on the contents. It was intended that there should be harmony among all the stakeholders concerning a document so crucial to the life and health of many people in the country. The deponent believed that the circular dated 24th February 2014 seeking to bar all health workers from being trained on safe abortion practices was merely a necessary sequel to the withdrawal of the guidelines.

170. Dr. Muraguri averred that in order to develop the desired consensus, the DMS convened a stakeholders' meeting during which the members deferred the document to the Maternal and New born Health Technical Working Group (MNHTWG) for review. Eventually, new guidelines were developed in 2014, the document is awaiting final editing, and presentation to the DMS for signature before it is released.

171. Dr. Muraguri averred that the DMS appreciated that any document that involves the lives and welfare of many people, and especially one that affects different faiths and beliefs, is difficult to complete especially in the light of the requirements of public participation contained in the Constitution. It was however, his case that the withdrawal of the document was for public good and for the purpose of making sure that provisions of the Constitution were observed.

172. As regards the Memo, Dr. Muraguri referred to Article 26 of the Constitution and opined that the said Article should afford this court the most important legal beacon in deciding this matter. In his view, it is apparent that the petitioners would rather rely on other collateral economic and social grounds to justify abortion at will thereby sacrificing the right to life of a constitutionally recognized person without any legally or constitutionally justifiable grounds.

173. It was the respondents' case that all health training in Kenya is regulated and permitted only by the Ministry of Health, which is responsible for policy matters concerning public health nationally. Towards this end, the government is continually preparing policy documents on numerous issues that affect society and it is necessary that training of persons not authorised by the Constitution to perform abortions be done, if at all, within a proper legal and policy framework.

174. He asserts that the numerous unwanted pregnancies in Kenya alluded to by the petitioners have been contributed to by the development of a liberal culture and lack of quality parenting, which has led to deterioration of morals as well as reckless life among the citizens in so far as sexual activity is concerned. Based on the petitioners' contention that seven out of ten women seeking abortion were not using modern contraception at the time of the pregnancy, it was his view that there is an incredible recklessness in light of the fact that Kenya has had very high literacy levels and public awareness on general issues, among them contraception.

175. Dr. Muraguri acknowledged that most abortions are normally carried out by unskilled persons using crude methods and in unhygienic environments. As a result, the country has been burdened by unnecessary deaths of the would-be mothers or massive costs, both pecuniary and social, of treating the complications and diseases including HIV/AIDS, which are suffered by those who survive the illegal abortion processes.

176. It was his case that there is no shortage of legal abortion services in public hospitals nationwide where the requested abortions meet the requirements of Article 26(4) of the Constitution, that is, where a trained health professional (not worker) has certified that there is need for emergency treatment or the life or health of the mother is in danger.

177. It was therefore his position that the actions on the part of the DMS have not violated any of the rights of the petitioners, but indeed have been tailored to ensure that the platform on which abortions are conducted in Kenya suit not just the petitioners but the public interest. He asserted that the government has striven to eliminate unskilled abortion providers and in so doing has always worked hard to avoid creating the public impression that it encourages abortion in a manner that is not allowed by the Constitution.

178. With regard to Medabon, it was his position that its use would not be proper if the abortion process is being conducted in contravention of Article 26(4), and the prohibition of the drug should be seen in this light. He contended that there is a likelihood that the unauthorized teaching of health workers on abortion may spawn a wave of illegal abortions countrywide. The respondents therefore prayed that the petition be dismissed as the government had demonstrated that it has the public interest at heart.

179. It was submitted on behalf of the Respondents that the actions complained of were meant to protect the women's physical health by reducing mortality and morbidity. It was further argued that judicial control of administrative authority is based on the doctrine of *ultra vires*, which informs the basis upon which the courts will interfere or intervene in matters of public administration.

180. In support of the position that the Ministry is the proper organ of the government to regulate training on abortion the DMS relied on the **Public Health Act (Cap 242)** which establishes the Central Board of Health tasked with, *inter alia*, advising the 2nd respondent on all matters affecting the public health. It was submitted that in issuing the Memo, the DMS acted in accordance with his powers under section 9 of the Act, and the Memo was based on information that some members of KOGS were training health care workers on the use of Medabon for purposes of conducting abortion. Further that this action was prohibited under section 158 of the **Penal Code**. That Article 26(1) guarantees the right to life, and, under Article 20(1), the Bill of Rights applies to all and binds all state organs and persons and the provisions of Article 20(3) bind this court. The court was urged to be alive to the provisions of Article 20(4) of the Constitution.

181. The respondents relied on the provisions of the **Pharmacy and Poisons Act (Cap 244) Laws of Kenya**, which establishes the Pharmacy and Poisons Board. The Board, whose members include the 2nd and 3rd respondent, has the authority to add, remove or classify medicines in the Kenya Essential Medicines List (KEML). While conceding that Medabon was included in the KEML published by the Ministries of Medical Services and Public Health and Sanitation in June 2010, it was submitted that the respondents, in exercise of their statutory authority, embarked on declassifying the same in a bid to establish alternative methods that will progressively realize the dictates of Article 26. Accordingly, the respondents submitted that the petitioners had not demonstrated with precision how the DMS's Memo was unreasonable nor how he exercised his discretion in an *ultra vires* manner.

182. The Respondents submitted that this being an executive act, this court can only interfere if it is shown that the authority in question was exercised unlawfully and unreasonably. In support of this submission the respondents cited the decision in **Associated Provincial Picture Houses Ltd vs. Wednesbury Corporation (1947) 2 ALL 680.** In their view, the orders sought by the petitioners are calculated at inviting this court to legalize abortion on demand, a situation that is likely to lead to a plethora (sic) of unsafe abortions.

183. With respect to the relevance and applicability of international general rules and treaties/conventions, cited by the petitioners and the interested parties, the respondents submitted that in spite of the provisions of Article 2 (5) and (6), such instruments have to be

interpreted in a manner that is consistent with the Constitution and respects the cumulative social structure of the Kenyan people. The respondents contended that the burden of proving constitutional violations and infringements rests with the petitioners. Reliance was placed on **Anarita Karimi Njeru vs. The Republic (1976-1980) KLR 1272** and **Meme vs. Republic & Anor [2004] eKLR**. In the respondents' view, beyond the generalities in regurgitating the constitutional provisions and international instruments, the petitioners have not precisely enumerated how their rights have been violated to entitle them to the orders sought.

184. The respondents relied on Black's Law Dictionary and medical jurisprudence as to when life begins and submitted that denying the child's right to life is an infringement and a violation of the unborn child's right to life protected under Article 26. In support of their submissions, the respondents relied on section 58 of the **United Kingdom English Offences Against the Person Act of 1861** and **Rex. vs. Bourne [1938] 3 All ER 615, [1939] 1 KB 687.**

185. As for the question whether the impugned Memo was in consonance with the dictates of fair administrative action under Article 47 of the Constitution, it was submitted that it is necessary for a petitioner to satisfy the court that constitutional requirements have not been adhered to. In this case however, the petitioners cannot state that their rights have been violated or infringed upon since the DMS convened a stake holders meeting to discuss and deliberate on changes of the document. As for what amounts to consultation, the respondents relied on **Republic vs. Judicial Service Commission Ex-Parte Pareno (2004) 1 KLR 203, Mombasa HC Constitutional Petition No. 76 of 2012 (Formerly Nairobi Petition 291 of 2011) SDV Transami Kenya Limited and 19 Others vs. The Attorney General & 3 Others, Maqoma vs. Sebe & Another 1987 (1) SA 483 and Nairobi Metropolitan PSV Sacco's Union Limited & 25 Others vs. County of Nairobi Government & 3 Others (2013) eKLR.**

186. The respondents similarly relied on section 5 of the Fair Administrative Action Act No. 4 of 2015 and submitted that leading up to the 24th February 2014 Memo, stakeholders were consulted in a participatory process and reasons for stopping the training given.

187. As regards the contention that the effect of the directive was to limit the pool of providers of the abortion service and hence endanger the life of survivors of sexual violence, it was submitted that proper education and awareness on contraceptives coupled with adequate health care support for pregnant women at whatever age would go a long way to curbing the vice, especially in the rural areas. While the respondents clarified that it is not in the interest of the 2nd respondent to stop sexual violence victims from accessing quality services but to get quality services, it was disclosed that the government has come up with the **National Post Abortion Manual Care Reference** dated 22nd May 2017 which is borne out of the need to equip reproductive health services providers with the necessary knowledge and skills to provide timely quality PAC services to reduce morbidity and mortality associated with the complications of abortions towards the achievement of MDG's and vision 2030.

188. The development of this manual, it was submitted was guided by current scientific evidence and is designed to equip health care workers with knowledge and skills that are necessary to provide quality post abortion care services. According to the respondents, this manual is the result of the concerted efforts of various individuals, institutions and stakeholders that developed through a series of meetings and workshops coordinated by the division of the reproductive health (DRH) under the leadership of the Ministries of Public Health and Sanitation and Medical Services.

189. It was therefore the respondents' case that the Ministry of Health addresses the number and extent of unsafe abortions occurring annually, hence sexual violence victims are well catered for in the guidelines.

190. The respondents further submitted on the legality of the relief sought in the petition and contended that the decision of a woman to choose whether or not to carry a pregnancy to term should not be left to the province of the individual's conscience. The petition, it was their view, is an attempt to expand the bounds of Article 26(4) to include circumstances that neither the Constitution nor any other written law contemplates contrary to sections 158 – 160 of the Penal Code.

191. It was the respondents' case that the abortion procured by JMM was not one that was certified by a professional medical doctor as one grimly necessary to preserve the life of the mother. The respondents likened the JMM case to the situation in the 1938 English case of **Rex. vs. Bourne [1938] 3 ALL ER 615, [1939] 1 KB 6867**.

192. According to the respondents, since a foetus has, pursuant to Article 26(1) and (2), a right to life, the state and this court are duty bound to protect such voiceless lives' right to life. It was therefore submitted that the argument that foetal rights are potentially subservient to the life of the mother is inhuman since being a living being albeit in developmental stage, a foetus automatically acquires legal personality deserving the protection of the law as any other Kenyan. The respondents therefore disagreed with the petitioners' notion that abortion is a purely private matter.

193. As regards the allegation of discrimination based on Article 27(1) (2) and (4), the respondents relied on **Willis vs The United Kingdom No. 36042/97, ECHR 2002 – IV** and **Federation of Women Lawyers Kenya (FIDA) vs. Attorney General & another [2018] eKLR)** in which the term "discrimination" was defined.

194. In the respondents' view, women in Kenya continue to get reproductive and antenatal healthcare services from any referral hospital or designated health facilities across the country without discrimination. However, Kenya, just like many other developing nations, grapples with lack of sufficient funds to guarantee world class healthcare as was appreciated by the South African Constitutional Court in **Soobramoney vs. Minister of Health (Kwazulu Natal) 1998 (1) SA 765 (CC)** and **Mathew Okwanda vs. Minister of Health and Medical Services & 3 Others [2013] eKLR.** The respondents submitted that JMM did get palliative care, albeit her health having since deteriorated and based on **Federation of Women Lawyers (FIDA-K) & 5 Others vs. Attorney General & Another Petition No. 2 of 2011** contended that socio-economic rights under Article 43 are subject to progressive realization.

195. In the respondents' view, there have been no limitation arising from the withdrawal of the 2012 Standards and Guidelines since existing health professionals are adequately trained to offer legal abortion. In this regard the respondents relied on the decision of the Supreme Court of Canada in the case of **Andrews vs. Law Society of British Columbia, [1989] 1 S.C.R. 143** and **Charles Omanga & Another vs. Independent Electoral and Boundaries Commission & Another [2012] eKLR**.

196. With respect to the argument about the psychological effect of the use of Medabon for abortions, the respondents relied on a publication titled **"Psychiatric Outcomes Following Medical and Surgical Abortion -Human Reproduction, March 2007, Volume 22, Issue 3, 1 at Pages 878–884, Oxford University, School of Medicine Publication of Medical Research by Sir Anthony J. Rothschild, Mitchell D. Creinin, Barbara H. Hanusa and Katherine L. Wisner**. It was submitted that the easy accessibility of Medabon for purposes

of abortion has serious possible outcomes, and it was this realisation that informed the decision by the Ministry of Health to issue a circular prohibiting the use of Medabon and a list of personnel that can offer abortion services.

197. To the question whether the withdrawal of the 2012 Standards and Guidelines affected legal abortion in the country, it was submitted that the withdrawn Standards and Guidelines were not written law as contemplated under Article 26(4) as read with Article 109 and section 2 of the **Interpretation and General Provisions Act (Cap 2)**. Accordingly, in the absence of permissive laws enacted pursuant to Article 26(4) aforesaid, the existing framework within which gynaecologists and obstetricians operate are regulated by sections 158-160 of the Penal Code. Since Parliament has not enacted legislation to give effect to Article 26(4), neither court nor the 1st – 3rd respondents have the jurisdiction or the powers to enact such laws. It was their case, nevertheless, despite withdrawal of the Standards and Guidelines, abortions to save the life of the mother are being conducted in the country, and in this respect reliance was placed on the Canadian Supreme Court decision in **Morgentaler vs. The Queen, [1976] 1 S.C.R. 616**.

198. It was contended that in applying Article 26(4), medical practitioners are expected to have at all times unimpaired judgment bearing in mind the existing law. In support of this position, the respondents relied on the decision of the Supreme Court of the United States of America in **Doe vs. Bolton, 410 U.S. 179 (1973)**. The respondents therefore argued that this court should not grant the orders sought in the petition as the decision to withdraw the 2012 Standards and Guidelines and the National Training Curriculum by the DMS was arrived at in accordance with the provisions of the law. In their view, the orders sought by the petitioners have the effect of curtailing the statutory duties and functions of the enforcement officers as provided for by law. They asserted that their actions were purely driven purely by public health interest, which is the golden thread that runs through all the laws cited herein, and thus the decision should be upheld.

The 2nd Interested Party's Case

199. The 2nd interested party, the **Kenya Christians Professionals Forum (KCPF)** joined the respondents in opposing the petition. It filed an affidavit in opposition sworn by its Chairperson, Anne Mbugua, an advocate of the High Court of Kenya.

200. Ms. Mbugua avers that the intention of Kenyans in Article 26(4) was to outlaw abortion on demand. That the understanding of Kenyans was that Article 26(4) would make it harder for any person to procure an abortion. It was therefore wrong to attempt an interpretation that liberalizes Article 26(4) to mean that abortion is available on demand or that it was available for pregnancy resulting from rape. In her understanding, Article 26(4) was supposed to protect the life of the child at all costs unless, in the opinion of a qualified health practitioner, the life of the mother is in grave danger or that there is need for emergency treatment or where permitted by any other written law. It was therefore her view that it is fallacious to argue that Article 26(4) repeals sections 158-160 and 240 of the Penal Code. According to her, Article 26(4) buttresses the law on abortion in Kenya.

201. She averred further that under the **Medical Practitioners and Dentists Act,** the Board is bestowed with supervisory powers over the delivery of health services and regulation of medical practitioners. Since the DMS is a member of the Board, his decision to withdraw the 2012 Standards and Guidelines and the National Training Curriculum and his

directive to all health workers not to participate in any training on safe abortion and the use of Medabon was within his mandate. She contended therefore that the said action cannot be termed as oppressive or arbitrary.

202. Ms. Mbugua took the position that section 35(3) of the **Sexual Offences Act** does not contemplate that the Guidelines for the Treatment of Victims of Sexual Assault shall be crafted in such a manner as to offend the clear stipulations of Article 26(2). Further, that the process leading to the Regulations pursuant to section 35(3) of the **Sexual Offences Act** was not consultative. It was her position that under Kenyan law, rape is not and has never been a legitimate reason for the conduct of abortion by health care professionals and even if such an allegation were to be true, rape cannot and should not be used so as to open the floodgates of allowing the killing of unborn children as a solution to unplanned pregnancy. She therefore averred that the sheer volume of the manifold reports and guidelines relied on in support of the petition are of little worth to this court as far as they are inconsistent with Articles 26(1), (2) and (4) of the Constitution.

203. In her view, abortion is allowed in the narrowest possible instances under the directions of a qualified health professional. She disagreed that there is complete inaccessibility to health services as those who study medicine in institutions of higher learning receive training on safe abortion.

204. Ms. Mbugua accused KOGS of having not only developed policies for the training of health officials but also of proceeding to train them without the involvement of the Ministry and the Medical Practitioners and Dentists Board. In her view, allowing prospective mothers to procure abortion wilfully means that the Constitution is being violated and the prayers in the petition are simply seeking the validation of such violations, contrary to the law that life begins at conception.

205. Regarding the provisions of the Maputo Protocol, Ms. Mbugua pointed out that there is a reservation to Article 14(2) (c). The Article obligates State Parties to protect the reproductive rights of women, by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. It was her contention that in view of this reservation, Kenya cannot be in violation of the Maputo Protocol regarding the provisions of Article 14(2) (c).

206. It was therefore the 2nd interested party's position that the Standards and Guidelines upon which this petition is premised are unconstitutional in light of Article 26(4) and therefore cannot form the basis for the alleged violation of rights since they are subordinate to the Constitution and therefore null and void to the extent of their inconsistency.

207. In her view, the person contemplated by Article 26(4) of the Constitution is a professional qualified in the giving of a qualified opinion and not just the technical aspects of inducing the termination of pregnancy. Accordingly, any training on the procuring of abortion that directs lower cadres of health care professionals to procure abortion without consulting a qualified health care professional is illegal.

208. The 1st interested party also filed an affidavit by one **Agneta Akech Aimba**, a member of KCPF and one of the founders of Pearls and Treasures Trust, an organization focused on helping women and girls who have undergone the trauma, shock and health complications resulting from the inducement of abortion. Ms. Aimba disclosed that she had encountered instances where many women, both young and old who, for a multiplicity of reasons, including unplanned pregnancies, fear of stigmatization and pregnancies as a result of rape, have procured abortion either on their own volition or due to pressure, duress, undue

influence and deceit from those around them including family and friends. She deposed that she had witnessed emotional and physical strain occasioned on the women and teenage girls by the procurement of abortion. In her view, there is a great need for emotional support to these women some of whom turn suicidal after having aborted. It was therefore her averment that 'safe abortion' is a term that serves to give the women and girls a false sense of hope and security and prompts them to undergo abortion following unplanned pregnancies.

209. According to Ms. Aimba, out of all the incidents they have handled, of those who have developed dire health challenges, 93% have sought these services from well to do outlets of health services hence there is no significant link between the place where the abortion is procured, the manner of the abortion, the persons involved and the trauma and feelings of worthlessness that follow after abortion. It was her evidence that having worked with post-abortive women in Kenya, all incidences she has encountered are from those suffering from post-abortion syndrome or post-abortion stress since abortion in whatever circumstance is a traumatic experience to the mother of the unborn child because in the end, there is always awareness on the part of the mother that they have terminated life.

210. Ms. Aimba averred that once the abortion has been done, emotions begins to settle in shortly thereafter. The first response from the mother, from the deponent's experience, is that there is a high propensity for justification of the act of abortion. Some argue in justification that they did this because they could not stand the stigma that came with teenage pregnancy; some could not withstand the thought of raising a child that reminded them of being raped; some argue that they were forced by their boyfriends among a myriad of many other reasons.

211. The second stage will involve attempts to suppress the feelings that arise as a result of the act of abortion and after most realize that they cannot suppress their feelings any longer. They seek out coping mechanisms for instance where there are feelings of depression, many turn to drug abuse, alcoholism, complete immersion in work and related undertakings and multiple sexual partners which further exposes them to further risk including sexually transmitted infections (STIs).

212. In her view, the feeling of worthlessness which follow abortion lead to the desire to find affirmation in other persons. This, she argues leads to multiple sexual activity with further risks of pregnancy and a real possibility of a continuous cycle of conception and abortion. Thus, she states, the initial problem solver turns out to be the start of a slippery slope without voluntary breaking points for the affected persons.

213. It was her belief, based on the foregoing, that access to abortion, whether legal or illegal, constitutes an act of deception that may wrongly lead women and young girls to think that killing their own children can be a remedy for a crisis pregnancy. She disclosed that they always undertake to help such individuals to confront the emotions and learn skills, which help in confronting sudden surges of emotion, and embark on a path to recovery.

214. A third affidavit in support of the 2nd interested party's case was sworn by Jacqueline Kadzo Gandi, a counsellor of over two years with Pearls and Treasures Trust. Ms. Gandi had prior to joining Pearls and Treasures Trust worked as a liaison person with Marie Stopes Kenya for over eight years. She averred that in her personal experience, most if not all of the cases they deal with at the Trust arise from abortions carried out not only in well to do clinics with the help of qualified health care professionals, but also with the aid of chemists that have backdoor areas for check-up and other public and private healthcare outlets of repute.

215. However, whereas the severity of the physiological consequences such as excessive bleeding and perforation of the uterine walls vary from one person to another, the difference has nothing to do with the place where and by whom the abortion is undertaken. It was her

evidence, based on her work experience, that the women and girls who seek to terminate pregnancies get the same on demand illegally. She averred that the health care professionals save for checking the period of the pregnancy in order to determine the best method to be used in the termination of the pregnancy, neither obtain parental consent nor assess the reason for seeking abortion, unless the same is at the request of the parent.

216. From her experience as a counsellor and having worked with Marie Stopes, none of those seeking help from them undergo abortion because of the reasons given under Article 26(4) but are based on social reasons.

217. A fourth affidavit in support of the 2nd interested party's case was sworn by Dr. J K Mutiso on 19th July, 2017. Dr. Mutiso is a medical practitioner, a specialist psychiatrist with a Master of Medicine degree in Psychiatry (M.Med Psych). He is registered with the Kenya Medical Practitioners and Dentists Board and was a past Chairman of the Kenya Psychiatry Association.

218. Dr. Mutiso avers that while rape, subsequent pregnancy, abortion, infection, kidney failure, dialysis and surgery are indeed traumatic experiences regardless of where, when, how or why the person experiences them, not all traumatic experiences lead to post-traumatic stress disorder (PTSD). He stated that, on the contrary, the majority of traumatic experiences resolve without any intervention with time. In his view, the risk of developing PTSD after rape, according to established peer reviewed published studies, is 20%. However, after diagnosing PTSD, the treatment protocol worldwide includes psychosocial support, counselling, psychotherapy, trauma therapy and prescribed medication as opposed to abortion.

219. He asserted that based on the documents relied upon by JMM, for at least two years after the rape, JMM did not get any psychological support. Accordingly, it was not confirmed by mental state evaluation by the Consultant Psychiatrist that JMM had developed phobia/fear of hospitals, medical staff and men and that she avoided situations that reminded her of her ordeal.

220. Since at the mental state evaluation by the Consultant Psychiatrist Dr. Pius Kigamwa, JMM denied any flashbacks, avoidance or hyper arousal symptoms, it was Dr. Mutiso's opinion that at the time of the mental state examination by Dr. Pius Kigamwa, JMM did not have PTSD. This was based on the fact that she had no past psychiatric history and had not received any psychological support. On the basis of the **Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM – V)**, which in his view is the diagnostic criteria for PTSD used worldwide, he averred that the conclusion made by Dr Kigamwa is unsupported. In his opinion, any of the disparate experiences JMM had to go through are potentially traumatic and had the issue been dealt with properly, the challenge of pregnancy having arisen from rape would be properly taken care of through foster care or adoption.

221. Like Jacqueline Kadzo Gandi and Anne Mbugua, Dr Mutiso averred that from his own experience, a majority of those who have gone to him for help due to the trauma arising from termination of the life of an unborn child terminated the pregnancies in reputable high end health facilities on demand, and, without any opinion being given in line with the constitutional threshold for the termination of a viable pregnancy. In his view, the stress experienced by post abortive women is normally linked to the fact that they know clearly well that they have terminated a viable life and often, as life progresses, they keep a record of the would be age of the children whose lives are cruelly ended through procedures that are akin to the one that JMM had to go through.

222. The 2nd interested party also relied on an affidavit sworn by one of its members, Dr Wahome Ngare, an Obstetrician Gynaecologist and a member of the KOGS, KMA and Kenya Catholic Doctors Association. Dr. Ngare also gave oral evidence on behalf of the 2nd interested party.

223. It was his evidence that 25% of the participants who helped develop and fund the development of the 2012 Standards and Guidelines subscribe to abortion being the right of the mother regardless of the rights of the unborn child. These organizations, which include the WH, UNFPA, IPAS African Alliance, Marie Stopes Kenya, Family Health International 360 and Family Health Options Kenya, though well-funded do not directly provide or offer a negligible percentage of health services. This is unlike the Catholic Church, which provides the bulk of health care in the private sector in the country, including maternal and child health care and was not included in the list of stakeholders. He further asserted that neither the Ministry of Education nor parents associations were involved in the development of the 2012 Standards and Guidelines.

224. According to Dr. Ngare, the terms used in the 2012 Standards and Guidelines and the Training Curriculum are only meant to create confusion. He was of the view that in lay medical terms in which the Constitution is written, abortion is the wilful killing of an unborn child (person) by deliberately terminating a pregnancy (wilfully procuring of a miscarriage) before the child can survive outside the mother or by use of a method that kills the unborn child before its delivery.

225. He accordingly averred that the drafters of the 2012 Standards and Guidelines either misrepresented or are incompetent in their understanding of sections 158-160 and 240 of the Penal Code and Article 26 of the Constitution, as well as section 2 of the 2012 Standards and Guidelines. In Dr. Ngare's view, Article 26 of the Constitution only confirmed and clarified what was already in existence and in practice in the medical profession in Kenya – that the onus of determining whether abortion is necessary or not is the prerogative of the trained health professional, a medical doctor, who has a heavy burden of giving a medically sound opinion before the life of the unborn child can be taken away.

226. It was his opinion therefore that any health professional not trained in the proficiency of giving an opinion that attempts or conducts an abortion and any prospective mother who attempts to or self-induces an abortion is guilty of a felony under the Penal Code. Similarly, any trained health professional who procures an abortion outside the restrictions set in Article 26(4) of the Constitution will also have committed a felony under the Penal Code.

227. It was also his deposition that even in the event the life of the mother is in danger, as a trained health professional, his training as a specialist and that of other doctors who are properly trained is to perceive the situation as one involving two human beings, the mother and the unborn child. They are therefore expected to take utmost care to ensure that there is the best possible chance for the survival of both the mother and the unborn child or in the worst-case scenario, the survival of the mother. However, the only health professionals trained to a level where they can give an opinion as to whether there is need for emergency treatment or the life of a pregnant mother is in danger are medical officers (doctors), not pharmacists, clinical officers, nurses, pharmaceutical technicians or any other cadre of health care professionals. In his view therefore, the decision whether or not an abortion is necessary is solely the responsibility and prerogative of the medical officer and not the mother.

228. Dr. Ngare averred that rape is a social issue, which should be addressed as such. In the event that conception occurs after rape, the life of the mother is not in danger, in which case the second perspective of the exceptions to the general rule in Article 26(4) cannot apply.

However, in light of the fact that health is defined broadly to include mental and social well-being, the opinion by a qualified health professional as to whether or not there is need to offer an abortion based on health grounds needs a multidisciplinary approach in which case a psychologist and a gynaecologist must be involved among others, including, in his view, a psychiatrist and spiritual leader. Even then, however, only grave and imminent danger to the health of the mother that is incapable of mitigation or management without harm to the child can ever justify an abortion and even then in the rarest of cases.

229. Based on reports from other jurisdictions, Dr. Ngare deposed that maternal mortality and morbidity are not directly attributable to 'unsafe abortion', since the said reports indicate that the rates of maternal morbidity and mortality remained high even after abortion was legalized. In his view therefore, the only way the government can successfully reduce maternal morbidity and mortality is by ensuring that there are sufficient resources, both human and capital, for the provision of pre-natal health care.

230. Dr. Ngare also took issue with the findings of the study titled **Incidences and Complications of Unsafe Abortion in Kenya** relied on by the petitioners as not being reflective of the proper statistics regarding the prevalence of complications which accompany 'unsafe abortion.' He described them are estimates based on a very controversial, non-scientific, deceptive estimation method that is only used by reproductive health rights groups called **Abortion Incidence Complications Methodology (AICM)** whose collection of data is heavily biased.

231. It was his position that the case of JMM, from a reading of the affidavit sworn by PKM, is a case of a crisis pregnancy, which is a social problem, which cannot be treated by termination of pregnancy. It was his opinion that the blame for situations such as JMM's should be placed on some of the men in this country who are not taking family responsibility seriously and their failure to be the moral keepers and protectors of their families. He therefore proposed that four steps to manage such situation be undertaken. First, there was need to seek medical advice immediately to collect evidence, prevent infections and rule out an already existing pregnancy. Secondly, there was also need for psychosocial support to help an unfortunate young woman who is defiled and has become pregnant. However, JMM was made to undergo abortion and developed both physical and psychological chronic conditions. Thirdly and more important, she could have been taken to a rescue home and be given the option of either keeping the baby or giving it up for adoption. The last option would have been family life education where sex is taught to children in the context of family and marriage life.

232. He therefore contended that the **2009 National Guidelines** is not proper in a medical or a legal sense. According to Dr. Ngare, though Kenya signed and ratified the Maputo Protocol, it did so with reservations against Article 14(2) (c) which was aimed at permitting abortion in the case of rape, which was against the Constitution. He insisted that the National Training Curriculum was withdrawn since it was being used as a manual to train health workers on helping mothers to procure abortion outside Article 26(4). Accordingly, the training that was being facilitated by KOGS was tainted with illegality, and, cannot be the basis of seeking protection at law. Moreover, he argued that it was developed without the involvement of all the stakeholders of the health sector, including the Catholic Church.

233. Dr. Ngare averred that all drugs used for the induction of labour are prescription drugs listed under the second part of the poisons list; they are controlled prescription medicines that should only be accessed with a prescription from a medical officer, which, according to the **Medical Practitioners and Dentist Board Act** means a qualified and registered medical

doctor. He explained that Medabon is a 'combi-pack' containing a tablet of Mife and four tablets of Miso and while Mife kills the unborn child and sensitizes the uterus to the effect, Miso induces cervical softening and uterus contractions leading to an abortion. It was his contention that although any health worker can be trained to use Medabon, they cannot be trained on how to give an opinion. However, since all gynaecologists have the capacity to give an opinion as to whether the health of a mother is in danger as part of their training, it is unnecessary to train nurses, clinical officers and pharmacists on how to administer Medabon. This must be so due to the potential side effects and especially the risk of incomplete abortion and resulting bleeding. Accordingly, the drug must be given in a controlled environment with the patient under supervision and with quick access to a theatre.

234. According to Dr Ngare, based on the bulletin that encompasses the presentations that were made during the 39th Kenya Obstetrical and Gynaecological Society Conference, there was evidence that certain non-governmental organizations had gone to the extent of making abortion-causing drugs like Misop available to women in the village who were advised to carry out the abortion on their own in violation of the Constitution and the **Pharmacy and Poisons Act.** To this extent, unsuspecting pregnant mothers are exposed to Medabon for purposes of inducing abortion but without knowledge as to the possible side effects and in the absence of the opinion of a qualified health professional as stated by the Constitution. He averred that the decision to administer drugs to induce abortion to an expectant mother was a medico-legal issue, which could be challenged at the level of the Medical Advisory Committee or similar bodies. However, in the absence of such a clear structure and referral system, there can be no way a chain of responsibility can be followed to bring to book those who flout the rules of medical procedure.

235. With respect to JMM, Dr. Ngare averred that while the manufacturers and WHO recommend that Medabon should only be used for termination of pregnancies below 9 weeks of gestation, her pregnancy was between 27-31 weeks during which time the baby's estimated weight would be 1.3 to 2 kilograms. When used in advanced pregnancy, medical abortion has a higher failure rate hence the need to resort to surgical or mechanical methods of termination.

236. In his view, since Medabon has only one indication i.e. termination of pregnancy by killing of the unborn child in all cases, it cannot be used to induce labour unlike Miso. Further, Medabon is easy to use and can be self-administered and therefore very easy to abuse if it lands in the wrong hands. Considering that self-induced abortion and abortion on demand are illegal in Kenya and that there are many safer drugs to use in place of Medabon, it was his opinion that there is absolutely no place for Medabon in the practice of medicine in this country and its importation and use should be banned altogether.

237. Dr Ngare expressed the view that his understanding was that most of the issues in the petition are straightforward and revolve around the understanding of what the drafters of the Constitution intended to mean by abortion and secondly, proper interpretation of Article 26(4). He stated that whereas the physical human life is a continuum from conception to natural death and exists in two different locations depending on the age of the human being – in and outside the womb - the dignity of human life is not conferred by its location or the size of the human being.

238. He further argued that considering the period required to train a doctor, spanning 5-6 years before they can give a professional opinion, such proficiency in training cannot be conferred (on other cadres of health workers) through a workshop held for a few days. He

therefore contended that as the law stands, giving of an opinion as to whether a pregnancy ought to be terminated is the preserve of medical officers-doctors and obstetric and gynaecologic specialists- who have received serious medical training.

239. In his view, all other professionals including counsellors, psychologists, sociologists, and religious leaders as well as health professionals ought to be involved in restoring the wellbeing of persons who find themselves in such difficult situations. He averred that this cannot be achieved if an untrained person gives an opinion that touches on various other spheres of the human life without proper involvement and consultation of other specialist professionals.

240. This is so, in his view, because rape is not a medical illness but a social problem. From his experience, the areas of contention in applying Article 26(4) are few and unlikely to involve the issue of emergency care or danger to the life of the mother, hence, the same cannot be used to justify the access of services for the termination of pregnancy on demand contrary to the express provisions of Article 26(4).

241. On the view that the options for medical abortion that are effectuated by means of Mife, Miso and Medabon are better and pose lesser risks to the woman who utilizes them to terminate the pregnancy, he stated that these drugs and their combinations as far as they are for the purpose of inducing the termination of a pregnancy, are not legal and evidence to the effect that they are registered ought to be tendered.

242. It was his position that as far as the training of a medical practitioner is concerned, since the life of the baby and the mother will be at stake if the proviso to Article 26(4) is met, the first thing to do is always to try and ensure that both lives can be saved, and only when it is impossible can the very constrained choice of saving the life of the mother be exercised legally. It is therefore out rightly illegal to use drugs or combinations of drugs that operate to kill the baby before inducement of labour.

243. In its submissions, the 2nd interested party contended that the petitioners hinge their case on the unfortunate case of JMM, a minor who was sexually violated and conceived following the alleged violation. While appreciating that a right cannot be litigated in a vacuum- that is absent a real violation, it was however submitted that the case used by the petitioners to propound a case for the violation of the attainment of the highest possible health standards is germane to the determination of this petition. It therefore urged the court to look keenly into the evidence supporting this case in order to make an informed and logical conclusion for the benefit of the people of Kenya. According to the 2nd interested party, aside from the fleeting mention of the events that led to the complications, the petition does not have much concerning the rape and abortion subsequent thereto.

244. The 2nd interested party further submitted that the replying affidavit of the DMS dated 28th August 2015 shows that the Ministry of Health is working towards a comprehensive document concerning the matters that are pertinent to this petition. More importantly, the new document will be aligned to Article 26 of the Constitution and shall involve all the relevant stakeholders. The rationale is to avoid a situation where names of certain stakeholders are used despite incorporation of amendments outside their knowledge.

245. After identifying what in its view were the issues for determination, the 2nd interested party urged the court that in the process of determining this petition, it should proscribe itself to the rule of law and not the opinion of a few individuals who have ascribed to themselves the power to determine what the law is. That, therefore, in order to determine what is the law for the people of Kenya, the court ought to resist the temptation of mixing political and personal choices that are disguised as liberty in a process that may be tantamount to a grand

exchange of the law and the rule of law for a rule by the whims of a few individuals. In this regard, the 2nd interested party relied on the dissenting dictum of **Curtis, J** in the case of **Dred Scott vs. Sandford, 19 How. 393, 621 (1857),** and submitted that this is clearly a case where the court is not being asked to determine whether or not there ought to be granted to a mother latitude to terminate the life of a unborn child but whether or not the laws of the people of Kenya as expressed in the Constitution, permit the termination of pregnancy at will without the consideration of the life of the unborn child.

246. It was however submitted that the right to life is the most sacrosanct right upon which all other rights under the Constitution are hinged hence there is no use for the Bill of Rights where there is no life. In this respect, the 2nd interested party relied on the decision of the Supreme Court in **Francis Karioko Muruatetu & Another vs. Republic [2017] eKLR**.

247. The 2nd interested party further submitted that the instant petition is a challenge to the right to life of an unborn child. However, the alleged reproductive rights cannot be viewed in isolation but must be viewed in terms of their end, which is the inescapable death of an unborn child yet under Article 26(2), this life begins at conception and the rights appurtenant to life therefore accrue immediately upon conception. It was therefore submitted that the Constitution ought to be interpreted in a manner that, as much as possible, seeks to realize the protection of the fundamental rights and freedoms, hence, despite the limit of residency for an unborn child, there is need to ensure that any process leading to their death is free, just and observes due process as per Articles 47 and 50 as much as possible in order to effectuate the requirements under Article 26(4).

248. The 2nd interested party proposed that there ought to be independent determination by one or more qualified health professionals as to whether a mother's life is in grave danger since the danger that Article 26(4) refers to is a danger that threatens to imminently take away the life of the mother if the pregnancy is not terminated. As to the manner in which rights under the Bill of Rights are to be enjoyed, the 2nd interested party submitted that since under Article 20(2) of the Constitution the court is bound to interpret the relevant law in a manner that most favours the preservation of the right to life, allowing indiscriminate abortion outside the confines of Article 26(4), is not in any way an interpretation that most favours the sanctity of the right to life.

249. According to the 2nd interested party, both the **Sexual Offences Act** and the **2009 National Guidelines** do not permit abortion and even if they did so, the position would be irredeemably unconstitutional. In support of this submissions, the 2nd interested party relied on **Republic vs. Jackson Namunya Tali [2014] eKLR**, **Dr Lucas Ndungu Munyua vs. Royal Media Services Limited & Another [2014] eKLR**, **Joseph Nyongesa Namukana v Republic [2010] eKLR** and **Kerosi Ondieki vs. Minister of State for Defence & Another [2010] eKLR** and submitted that a plain reading of that Article shows that the drafters of the Constitution meant to have qualified doctors shouldering the heavy responsibility of determining the health consequences of keeping of a pregnancy. In its view, it is therefore out rightly illegal for persons to administer noxious substances to pregnant girls or women with the intention of causing the termination of a pregnancy outside the opinion of a qualified and trained health care professional.

250. It was further submitted that just as a midwife who is trained by members of the KOGS fraternity outside the parameters of the law is not a health care professional, in the same way, a woman who is trained by persons from KOGS on how to use Medabon is not a health care professional. In the 2nd interested party's view, a woman who, because of rape, has conceived cannot be deemed to be of the requisite mental forte let alone professional qualification to

have the capacity to determine whether or not a pregnancy ought to be terminated. As to what amounts to emergency treatment, reliance was placed on the decision of the Supreme Court of India in **Parmand Katra vs. Union of India AIR (1989) SC 2039.**

251. As a further illustration of what an emergency medical treatment is, the 2nd interested party relied on section 7 of the **Health Act** which views emergency treatment as a right by providing that it includes pre-hospital care and stabilizing the health status of the individual. The 2nd interested party's interpretation of the said provision was that the Act does not include performing procedures on a person as being an emergency treatment but instead, indicates that emergency treatments mean conducting a procedure to help stabilize the patient and remove the patient from danger.

252. It was therefore submitted that the life of a mother being in danger means that she is in a situation whereby she cannot continue to carry the baby and hence the only solution would be to terminate the pregnancy or else the mother dies. However, this legal position does not mean that a pregnant woman can terminate her pregnancy based on feelings or personal choices and the court was urged to be persuaded by the precedents set forth by the Indian Court.

253. Concerning the alleged violation of the Maputo Protocol, it was submitted that during ratification, Kenya made a reservation to that clause, and it is therefore not binding. Reference was made to the **Treaty Making and Ratification Act** No. 45 of 2012 which defines reservation to mean a unilateral statement made by the state when signing, ratifying, accepting, approving or acceding to a treaty, whereby it is intended to exclude or to modify the legal effects of certain provisions of the treaty in the application to the state. Reference was also made to section 8, which grants the National Assembly powers to approve the ratification of a treaty with reservations to specific provisions of the treaty. It was contended that on 6th October 2010, the government through the relevant ministry, reserved the clause on abortion provided for under the Maputo Protocol and this was after the Constitution of Kenya 2010 had been promulgated; hence the said reservation was a clear position as regards the issue of abortion in the Constitution.

254. Regarding the definition of a 'trained health professional', the 2nd interested party relied on section 6 of the **Health Act.** The section refers to one with a formal medical training at the proficiency level of a medical officer, a nurse, midwife or a clinical officer who has been educated and trained to proficiency in the skills needed to manage pregnancy-related complications in women, and who has a valid license from the recognized regulatory authorities to carry out that procedure.

255. It was the 2nd interested party's case that the DMS, an office which was replaced by the Director General of Health under the **Health Act 2017,** has the oversight Authority over the health sector. His mandate was provided for under the repealed section 3 of the **Public Health Act,** which has has been replaced by the provisions of sections 16 & 17 of the **Public Health Act, 2017**. It was further submitted that the **Medical Practitioners and Dentists Act** provides for the registration of medical practitioners and dentists in Kenya, a task solely placed upon the Board which is created under the Act, which Board plays a role in regulating and enhancing the skills of the medical practitioners and comprises of *inter alia* the DMS.

256. It was therefore submitted that based on the above list, the DMS is part of and the Chief Executive Officer of the Board and therefore can communicate decisions made by the Board. Accordingly, the directive issued by the DMS was within his mandate as a member of the Board. This is so because the Board is tasked with regulating trainings undertaken by the medical practitioners since the **Medical Practitioners and Dentists (Training, Assessment**

and Registration) Rules, 2014 creates a Training, Assessment and Registration Committee meant to implement the continuing professional development programmes by the Board. Once the Board has organized for a training of the medical professionals, the Committee then brings the same into fruition.

257. It was further submitted that section 3 of the **Public Health Act**, recognizes the role of health regulatory bodies established under any written law and distinguishes their regulatory role from the policy making function of the national government. This means that this specific Act acknowledges the fact that a medical board formed and created under the **Medical Practitioners and Dentists Act** plays a regulatory role in the medical profession. It was therefore contended that the allegations that the DMS acted *ultra vires* are baseless since the law clearly established the portfolio of the DMS and grants the official the mandate of oversight, research and professional development of relevant professionals in the health sector.

258. As to whether the withdrawal of the 2012 Standards and Guidelines and the National Training Curriculum occasioned prejudice to the petitioners, it was submitted that, based on the review of the case of JMM and generally the evidence on record, no prejudice was occasioned. To the contrary, the withdrawal of the 2012 Standards and Guidelines is a step in the right direction if the persons who assisted JMM in accessing pregnancy termination services are ever going to be brought to book.

259. According to the 2nd interested party, the 2012 Standards and Guidelines were withdrawn when it became apparent that they had been developed without the input of key stakeholders. Furthermore, the 2012 Standards and Guidelines had been amended without the knowledge of some of the persons who were cited as having been involved in the process that led to their launch. This being the case, there was foul play in the textual outlook of the 2012 Standards and Guidelines and there is every possibility that they contained clauses and provisions that had not been, on the basis of consensus, acceded to by all the relevant stakeholders.

260. Furthermore, it was becoming apparent that some of the members were using the 2012 Standards and Guidelines to offer training to persons not qualified in law. As a matter of fact, the reasons for the crafting of such rules would be lost if the 2012 Standards and Guidelines were to be used by quacks and expectant mothers everywhere and anywhere. In such a case, maternal morbidity and mortality would be fanned and not reduced.

261. Regarding JMM, it was submitted that it had not been demonstrated that she suffered any loss or injury as a result of the withdrawal of the 2012 Standards and Guidelines. Regarding the other petitioners, it was submitted that the withdrawal was informed by good intentions and public interest and that the DMS acted in keeping with the attendant discretion granted to his office and did not act unreasonably. As a matter of fact, having in mind the law on abortion and also the possible consequences of proliferation of unregulated and reckless termination of pregnancy outside the supervisions of a qualified healthcare professional, the DMS, in withdrawing the 2012 Standards and Guidelines, acted reasonably.

262. It was the view of the 2nd interested party that this court is being asked to make a political choice and not a legal one. Reliance was placed in this regard on **Judges & Magistrates Vetting Board & Others vs. Centre for Human Rights & Democracy & others [2014] eKLR**, **The Matter of the Principle of Gender Representation in the National Assembly and the Senate [2012] eKLR**, **Jasbir Singh Rai & 3 Others vs. Tarlochan Singh Rai & 4 Others, Sup. Ct. Pet. No. 4 of 2012; [2013] eKLR** and **Anarita**

Karimi Njeru vs. The Republic (1976-1980) KLR 1272 and it was argued that in being persuaded of the right thing to do, courts of law ought to desist from working on the basis of lofty ideals.

263. The 2nd interested party proposed a similar system to that of India where a Board has to sit and agree, on the basis of medical evidence and preponderance of opinion, that there is need to procure an abortion. To support this proposition, the 2nd interested party relied on the **Sheetal Shankar Case** (supra). Based on the holding in the case, it was submitted that this is evidence of the fact that nothing in the legitimate actions of the DMS shall impede anyone from accessing health care legitimately and hence this court should disregard the submissions of the petitioners. It was therefore the view of the 2nd interested party that the actions of the DMS were not capricious.

264. As regards the allegations of violation of human rights, it was submitted that the petitioners have not established that through the case of JMM these rights have been breached. Moreover, apart from the rights that are designated as being non-derogable including freedom from slavery and servitude, Article 24 of the Constitution provides for instances where rights and fundamental freedoms can be limited and as long as the limitations are legitimate and founded on reasonable grounds, the court ought to restrain itself from ignoring such limitation. It was also submitted that rights cannot be litigated in a vacuum and the case of JMM, however unfortunate, cannot be used to anchor the petition that she developed complications owing to violation of the law. As to whether rights can be limited reference was made to the decisions in **Famy Care Limited v Public Procurement Administrative Review Board & another & 4 others [2012] eKLR** and **Barbra Georgina Khaemba vs. Cabinet Secretary, National Treasury & another [2016] eKLR**.

265. The 2nd interested party submitted that it has shown that it is the legal mandate of the DMS to oversee the health sector and hence it would be useless to create such a portfolio if the office did not have the powers listed under sections 16 and 17 of the **Health Act 2017**. Where there is a violation of the law and public policy matters pertaining to health, the law gives discretion to the office to act in the public interest. It was submitted therefore that the DMS acted within the law and that a challenge to the mandate and reasonableness of his actions cannot be sustained. In this regard reliance was sought from the case of **Cementia Holding Ag & Another vs. Capital Markets Authority & 3 Others [2014] eKLR** to illustrate that where statute grants powers to an office, all the attendant powers necessary for the effectuation of the mandate are given as long as the powers are exercised reasonably.

266. Based on the decision of **Lord Diplock** in **Council of Civil Service Unions vs. Minister for the Civil Service [1983] UKHL 6** it was submitted that the actions of the DMS were reasonable and in public interest. Accordingly, it was asserted that where an authority is acting within its legal mandate, the recipients of decisions which are legal should not be allowed to escape liability because they think their rights have been violated and this assertion was based on **Garissa Madogo Matatu Savings and Credit Cooperative Society Limited vs. Municipal Council of Garissa [2013] eKLR.** It was therefore submitted that the claim for violation of fair administrative action by the petitioners cannot and should not suffice and since this court sits to do justice, the petitioners, whose hands are tainted with illegality, cannot come to this court seeking reprieve or the legitimization of illegal activity.

267. As regards the balancing of individual and communitarian perspective to human rights, it was submitted that there arises a need to balance the right to life of the mother and the state's interest in protecting pre-natal life as the failure to do so negates the very heart of

Article 26. Contrary to the assertions of the petitioners, it would render the intention of the drafters of the Constitution meaningless to give foetus rights that cannot be protected.

268. As to the proper interpretation to Article 26(4), it was reiterated that since the Constitution is home grown and rooted in native soil, the Constitution owes its validity and authority to local legal factors, rather than to the fact of enactment by a foreign legal process, and this caution should be taken while interpreting the Constitution against the backdrop of foreign jurisprudence. In this regard the 2nd interested party relied on **Nelson Andayi Havi vs. Law Society of Kenya & 3 Others [2018] eKLR; Petition No. 607 of 2017**, and emphasized that the interpretation of the Constitution in Kenya should be geared towards realizing its purposes, values and principles as stipulated in Article 259(1), and among the purposes of the Constitution is to protect every person's right to life, including protection of pre-natal life hence the inclusion of Article 26. In light of the foregoing, it is important to create our own precedence guided by the autochthonous nature of our Constitution and in this respect reliance was placed on a journal article titled: **Casey: Enduring, Entrenched, Intentionally Evil Egregious Error**, in which **Michael Stokes Paulsen** explains the colossal magnitude of the 1992 U.S Supreme Court decision in **Planned Parenthood v Casey** in which the Supreme Court re-affirmed the decision in **Roe v Wade**.

269. The 2nd interested party submitted that Article 26(4) only provides a limitation to the core right and it has to be construed as narrowly as possible so that it does not take away from the core right stipulated under Article 26(1), (2) and (3) and associated rights under Article 27(1), (2) and (4). It was therefore the 2nd interested parties' position that this petition ought to be dismissed in its entirety and with costs.

The 3rd Interested Party's Case

270. The 3rd Interested Party, **Catholic Doctors Association**, similarly opposed the petition. **Dr. Stephen Karanja** swore an affidavit dated 1st August 2016 and a further affidavit dated 14th September 2016. It was his testimony that under Article 26 (2) the right to life begins at conception. Further, that Article 3 of the **Universal Declaration of Human Rights (UDHR), 1948,** provides that everyone has a right to life, liberty and security.

271. **Dr. Karanja** contended that the DMS withdrew the 2012 Standards and Guidelines as they did not serve their intended purpose, owing to the involvement of health workers without the permission of the Ministry of Health. It was his testimony that from his experience, abortion ought to be performed only by trained health professionals due to its complex nature.

272. Dr. Karanja averred that the DMS, as the statutory body mandated to regulate the practice of medicine, was within his powers to put a stop to all trainings that would endanger the lives of Kenyan people. Further, that the use of Medabon endangers the lives of more women and girls because the side effects of the drug are not well documented.

273. It was his testimony that the right to life should attach as soon as the life is created at the moment of fertilization, in accordance with Article 26 (2) and Article 6 of the **ICCPR**.

274. The 3rd interested party submitted that at the time JMM underwent the unsafe abortion procedure, her life was not in danger and her case did not satisfy the criteria under Article 26(4). A decision was however made to terminate the pregnancy, which resulted in JMM developing complications. It was its submission further that an unborn child is a distinct and separate individual from the woman carrying it, and as such, it is considered equal before the law and has the right to equal protection and benefit of the law as provided under Article

27(1). The 3rd interested party argued that the life of an unborn child, despite its development stage, has inherent dignity which must be respected and protected as conferred by the right to dignity under Article 28.

275. The 3rd interested party cited several international instruments to support the argument that the right to life extends to the unborn child and no attempt whatsoever has been made to exclude any development phase of human life. It referred the court to Articles 3 and 6 of the **UDHR;** Article 10 (2) of the **ICESCR; Articles 3** and **18** of the **ACHPR** and **Paragraph 9** of the preamble of the **CRC**, which recognizes the protection of the unborn child.

276. It further referred the court to the case of **Oliver Brustle v Green Peace Case No. C-34/10** where the European Court of Justice held that:

> ***"Any human ovum must, as soon as fertilized, be regarded as a 'human embryo' if that fertilization is as such as to commence the process of development of a human being."***

277. The 3rd interested party further cited the case of **A, B and C v Ireland [2011] 53 EHRR 13** in which the Grand Chamber of the European Court of Human Rights held that Article 8 of the **ECHR,** being the right to respect private and family life, cannot be deemed as a right to abortion. The Court also appreciated the rights of the mother and the child are inextricably interconnected and the profound right to life of the unborn child.

278. It was the 3rd interested party's submission that the Constitution is to be interpreted in a holistic manner as was explained in the **Matter of the Kenya National Human Rights Commission [2014] eKLR para 26, cited in CCK v Royal Media Services Ltd.**

279. The 3rd interested party submitted that the wording of **Article 26(4)** when interpreted holistically does not advocate for taking away the life of the unborn child whose life has been acknowledged and protected, but instead is intended to save the life of the mother which is in danger. The withdrawal of the 2012 Standards and Guidelines and the Training Curriculum together with the ban on the use of Medabon was therefore occasioned by their unconstitutional use by the pro-abortionists in Kenya.

280. The 3rd interested party further submitted that the purpose behind **Article 26** was people centred and intended to protect their lives. It contended that the aspirations of the people of Kenya were clearly reflected in preparatory documents to the Constitution in which it was indicated that Kenyans did not want abortion.

The Case of the 7th Interested Party

281. **Ms Nazlin Umar**, the 7th interested party, filed an affidavit dated 10th May 2016 in opposition to the petition and urged the Court to take it as her submission as well. It was her testimony that the government has Level 5 Hospitals across the country and if a clinical officer is of the opinion that a mother's life is at risk, the officer should refer her to the appropriate medical facility.

282. In her oral submissions, she stated that the Constitution in its introduction recognized the Almighty God while **Article 26(2)** states that life begins at conception. She further submitted that all holy books- such as the Bible and the Quran- are clear that the right to life is sacred, and she referred the court to chapters 5 and 17 of the ***Quran*.**

Submissions by the *Amicus*

283. The 1st *Amicus Curiae*, **Women Link Worldwide**, relied on the Inter-American Court of Human Rights case **Artavia Murillo Et Al. ("In Vitro Fertilization") v. Costa Rica** to argue that the right to life from conception is not absolute and cannot be used to restrict other rights disproportionately, or to discriminate. Further, that the right to life from conception does not give pre-natal life the status of a person.

284. On the right to benefit from scientific progress regarding sexual and reproductive health, it was the 1st *Amicus Curiae's* submission that in Kenya, the right to benefit from scientific progress is expressed under Article 11 of the Constitution which states that **"The State shall recognise the role of science… in the development of the nation."** It is also recognised in **Article 33(1)**, which provides that **"every person has … the freedom of scientific research."** The 1st *Amicus Curiae* argued that the 3rd respondent has unlawfully restricted access of women and girls in Kenya to scientific progress by banning the safer, affordable, less-invasive and up-to-date option (Medabon) which has been made available by science and approved within the country as essential.

285. The 2nd *Amicus Curiae*, the **National Gender and Equality Commission,** relied on the **NGEC and UN Women Report 'Determining the Economic Burden of Gender Based Violence to Survivors in Kenya' [2015]** to argue that sexual violence imposes both direct and indirect costs on women and girls, their households and the society. It also referred the court to the recent changes in law in other countries in Africa, which now provide guidance on how to ensure access to safe and legal abortion for survivors of sexual violence. It noted that in 2005, Ethiopia reformed its **Criminal Code** Article 551 to specifically and clearly allow for abortion in cases of rape and incest. Furthermore, the Ministry of Health in Ethiopia has provided clarity by providing Guidelines in the form of the **Family Health Department Technical and procedural guidelines for safe abortion services in Ethiopia 12 [2006]**. The Guidelines clarify that women need not provide any documentation concerning rape: their request for abortion and pregnancy results from sexual violence is sufficient to obtain a legal abortion. The Guidelines further provide that health providers will not be prosecuted in the event the woman's allegation is eventually proven false.

286. The 3rd *Amicus Curiae*, the **Kenya National Commission on Human Rights (KNCHR)** confined its submissions to analysing the question whether the lack of a statutory and physical framework to protect, facilitate and implement the right under Article 26(4) violates women and girls rights to life, dignity and freedom from torture and cruel, inhuman or degrading treatment, right to equality and non-discrimination, right to information, right to goods and services of reasonable quality, amongst others. It was its submission that the phrase *"if permitted by any other law"* as used in Article 26(4) means that beside constitutional exceptions, a law can permit abortion based on other grounds. It noted the provisions of section 35(3) of the **Sexual Offences Act** in this regard. It submitted that the **2009 National Guidelines**, although developed before the 2010 Constitution, reflect the spirit of Articles 26(4), 28 and 29 (d) and (f) of the Constitution.

287. **KNCHR** submitted that the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum have the effect of interfering with the availability, accessibility, acceptability and quality of health care services to women, and that they had the further effect of imposing a particular hardship to poor and rural women in seeking the same services.

288. It argued that forcing a woman to keep a pregnancy resulting from sexual abuse is in contravention of Articles 29(d) and 25(1). Further, it was **KNCHR's** submission that both Articles 2(4) and 165(3) (b) give this court the power to invalidate any act or omission that is

in contravention of the Constitution. This power of the court is consistent with the obligation of the court to be the final custodian of the constitution. **KNCHR** relied on the decision in **Jayne Mati & Another v Attorney General & Another Nairobi Petition No. 108 of 2011.**

Analysis and Determination

289. We have considered the pleadings of the parties and their oral and documentary evidence, as well as their written submissions. We have deliberately set out these pleadings and submissions at some length, conscious as we are of the importance of the subject before us, and the conflicting emotions and positions that it arouses. The stated subject of the petition is the withdrawal of the **2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya** and the **National Training Curriculum for the Management of Unintended, Risky and Unplanned Pregnancies**. These documents were withdrawn by the DMS by a letter dated 3rd December 2013. A Memo dated 24th February 2014 withdrew the **National Training Curriculum**. The DMS threatened dire legal and professional consequences for those who continued to engage in such trainings.

290. Hovering over the subject of this petition is the spectre of **JMM**, an eighteen year old girl who died during the pendency of this petition and is represented in the proceedings by her mother and next friend, **PKM**. She represents for the petitioners the many other silent ghosts of young women who die in the process of trying to get rid of unwanted pregnancies. The petitioners view the withdrawal of the 2012 Standards and Guidelines as taking away the last shred of hope for the likes of JMM.

291. There is, however, another set of 'victims', whom the respondents and the 2nd, 3rd and 7th interested parties speak so eloquently for. These are the unborn children. The respondents and these interested parties see the 2012 Standards and Guidelines and the Training Curriculum as sounding the death knell for these unborn children. They see the documents as opening the door for abortion on demand.

292. We thus have the parties before us starting from two diametrically opposed positions on the core issue. The petitioners and the 1st, 5th and 6th interested parties start from the premise that the Constitution, at Article 26(4), permits abortion in cases of pregnancy resulting from sexual violence. The respondents and the 2nd, 3rd and 7th interested parties start from the premise that the Constitution does not permit abortion save where the life or health of the mother is in danger, regardless of the circumstances under which a pregnancy occurs. (For the sake of brevity, we shall, where appropriate in the course of this analysis, refer to the petitioners and the interested parties who support them as **'the petitioners'** and the respondents and those who support them as **'the respondents')**.

293. There is a further point of departure between the parties. For the respondents, *'health'* refers to the physical health of the mother, and they contend that Article 26(4) permits abortion in the narrowest of circumstances where the life and physical health of the mother is in danger. The petitioners take the view that the Constitution allows abortion where both the physical *and* psychological health of the mother is endangered by a pregnancy.

294. The parties are also at odds with respect to *who* should make a determination with respect to whether or not a pregnancy poses danger to the life or health of the mother. While both the petitioners and the respondents agree that the determination should be made by a trained health professional, they are at great odds as to what *'trained health professional'* means. For the petitioners, a 'trained health professional' includes nurses, midwives and clinical officers as defined in the **Health Act, 2017**. The respondents argue that the term means or should be taken to mean medical doctors only.

295. Accordingly, we take the view that the following issues arise for determination:

> ***i. Whether Article 26(4) permits abortion in certain circumstances;***
>
> ***ii. Who is a trained health professional for the purposes of Article 26(4)?***
>
> ***iii. What does the right to health and the right to reproductive health entail?***
>
> ***iv. Whether pregnancy resulting from sexual violence falls under the permissible circumstances for abortion under Article 26(4);***
>
> ***v. Whether the DMS's impugned letter and memo meet the test for limitation of rights set out in Article 24;***
>
> ***vi. Whether the decision to withdraw the 2012 Standards and Guidelines and Training Curriculum and to issue the Memo violated Articles 10 and 47 and was ultra vires the powers of the DMS;***
>
> ***vii. Whether the decision of the DMS in (v) above violated the petitioners' rights and the rights of other women of reproductive age guaranteed in Articles 26, 27, 29, 33, 35, 43 and 46;***
>
> ***viii. Whether the decision of the DMS violated the rights of health workers guaranteed in Articles 32, 33, 34, 35 and 37;***
>
> ***ix. Whether the circumstances of JMM qualified her for post-abortal care under Article 43;***
>
> ***x. Whether PKM as the personal representative of the estate of JMM is entitled to comprehensive reparation including indemnification for material and emotional harm suffered as a result of the actions of the respondents.***

296. We recognise that we are not dealing with an easy matter. We are called upon to pick or make the best of a bad situation. This is informed by the fact, conceded by all the parties, that there is a great problem arising from pregnancies which lead to unsafe abortions, and often, death of the would be mothers. The petitioners argue that the solution lies in a situation where the state provides information, standards, and guidelines on access to safe abortion where pregnancy results from sexual violence. The respondents see the problem as being a social problem, which can only be dealt with in the context of family sex education.

297. We recognise also that we are called upon to make a determination on the meaning and implication of Article 26(4) of the Constitution. Thus, this petition turns on the interpretation of Article 26 which provides as follows:

> 1. ***Every person has the right to life.***
>
> 2. ***The life of a person begins at conception.***
>
> 3. ***A person shall not be deprived of life intentionally, except to the extent authorised by this Constitution or other written law.***
>
> 4. ***Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.*** (Emphasis added)

298. It, however, does not come to us as a surprise that the interpretation of this Article has found its way before the court. It was one of the Articles that was flagged out as a contentious question during the deliberations leading to the Constitution. According to the ***Final Report of the Committee of Experts on Constitutional Review:***

"One of the most significant changes made in the Bill of Rights by the PSC was to Article 31 of the RHDC on the right to life. The right to life appeared in Article 25 of the PSC Draft with two new clauses: clause (2) stating: "The life of a person begins at conception" and clause (4) stating "Abortion is not permitted unless in the opinion of a registered medical practitioner the life of the mother is in danger." Despite reservations regarding its formulation, the CoE left the statement in clause (2) that "life begins at conception" intact because the PSC pointed out that this was a "deal breaker" (or deal maker) in getting some sections of the religious sector to support the Proposed Constitution. (That did not turn out to be the case as the discussion of civic education below shows.)

It should be noted that the reformulated provision was itself contrary to Article 31 of the PSC Draft on freedom of conscience, religion, belief and opinion, and there are different views held on when life begins. Muslims believe life beings at "ensoulment", which is on the 40th day of a pregnancy, while some Christian churches believe it starts at "quickening" (at about 12 weeks' from conception). Traditionalists believe life begins at birth and scientists have varied other opinions. Some people believe that life begins before conception.

The proposed clause (4) was unusual by international standards. Only a handful of countries, such as El Salvador, Nicaragua and Bolivia have clear references to abortion in their constitution. Moreover, medical practitioners raised concerns about the new wording which forbade abortion, pointing out that abortion may be spontaneous (miscarriage), and therefore could not be prohibited or "permitted". Secondly, the medical practitioners said, there are situations where the mother's life is not in danger but her health would be seriously damaged if an abortion was not performed or where an operation on her reproductive organs would result in an abortion. Examples include tumors which present as what appear to be pregnancies or ectopic pregnancies which, if not terminated, could result in infertility or even death. The requirement that abortion could be performed by medical practitioners alone also raised concerns. It would mean that women in poor rural communities without such services would be unable to procure abortions with potentially serious or fatal repercussions for some poor women. There was also need to ensure that the language used by the PSC did not outlaw methods of fertility control, such as emergency contraception. The CoE accordingly amended the draft to include language that would enable appropriate medical intervention to be available when necessary.

299. What emerges from the foregoing is that the end product that was incorporated in Article 26 was a compromise of the differing views expressed by the various camps. We have set out the circumstances leading to the present Article since in our view those circumstances are important in understanding the rationale behind the Article. As was appreciated by a majority in **Njoya & 6 Others vs. Attorney General & Others (No. 2) [2004] 1 KLR 261; [2004] 1 EA 194; [2008] 2 KLR**, the Constitution should be given a broad, liberal and purposive interpretation to give effect to its fundamental values and principles. That purposive approach, it was explained by the Supreme Court **In the Matter of the Principle of Gender Representation in the National Assembly and The Senate Advisory Opinion Application No. 2 of 2012,** would take into account the agonized history attending Kenya's constitutional reform. Therefore as was held in **Murungaru vs. Kenya Anti-Corruption Commission & Another Nairobi HCMCA No. 54 of 2006 [2006] 2 KLR 733**, our Constitution must be interpreted within the context of social and economic development keeping in mind the basic

philosophy behind the particular provisions of the Constitution. Dealing with what holistic interpretation connotes, the Supreme Court in the **Matter of the Kenya National Human Rights Commission, Advisory Opinion No. 1 of 2012; [2014] eKLR**, at paragraph 26 held that:

> ***"It must mean interpreting the Constitution in context. It is the contextual analysis of a constitutional provision, reading it alongside and against other provisions, so as to maintain a rational explication of what the Constitution must be taken to mean in light of its history, of the issues in dispute, and of the prevailing circumstances. Such scheme of interpretation does not mean an unbridled extrapolation of discrete constitutional provisions into each other, so as to arrive at a desired result."***

300. As a result of the said compromise, one of the fundamental changes made to the Parliamentary Select Committee on the Review of the Constitution (PSC Draft) was the substitution of the term "registered medical practitioner" with "a trained health professional." This, as was appreciated by the Committee, was due to the fact that the requirement that abortion could be performed by medical practitioners alone would mean that women in poor rural communities without such services would be unable to procure abortions with potentially serious or fatal repercussions for some poor women. In other words, the Committee appreciated that in rural areas where majority of Kenyans live, there is a scarcity of the services of registered medical practitioners. In fact, it was common ground before us, that medical practitioners are unavailable in dispensaries and health centres, which serve the majority of Kenyans. It is therefore with this realisation in mind that we proceed to determine this petition.

301. We need not state that Article 26 (1) applies to a natural person as opposed to a legal person. According to Article 26(2), the life of such a person begins at conception. We did not understand any of the parties to these proceedings to take issue with these provisions. In fact, they could not since Article 2(3) of the Constitution bars any challenge being taken to the validity or legality of the Constitution.

302. What then is conception? Without any party advancing a different meaning from that given to the word by ***Black's Law dictionary***, we are constrained to apply that definition which is that conception is **"*the fecundation of the female ovum by the male spermatozoon resulting in human life capable of survival and maturation under normal conditions.*"**

303. Since life begins at conception, the Constitution is clear that a person shall not be deprived of life intentionally, except to the extent authorised by the Constitution or other written law. Article 26(4) then proceeds to deal with the contentious subject of abortion. It is telling, in our view that the drafters of the Constitution deemed it fit to deal with the said subject under the Article dealing with the right to life. To our mind that was not by inadvertence. It is our view that the drafters of the Constitution considered abortion as an intentional deprivation of a life. Accordingly, abortion must be contradistinguished from miscarriage. We therefore do not agree with the position adopted by the respondents that the word abortion as applied in Article 26(4) applies to miscarriage. We associate ourselves with the decision in **Domnic Arony Amolo vs. Attorney General Miscellaneous Application No. 494 of 2003** that interpretation of the Constitution has to be progressive and in the words of **Prof M V Plyee** in his book, ***Constitution of the World*** that:

> ***"The Courts are not to give traditional meaning to the words and phrases of the Constitution as they stood at the time the Constitution was framed but to give broader connotation to such words and connotation in the context of the changing***

needs of time."

304. The elephant in the room, if we may term it so, as far as Article 26 is concerned, is the true interpretation of Article 26(4). It is true that the opening statement of the said Article is that abortion is not permitted. That, in our view, is the general rule. The drafters of the Constitution must have had a very good reason for opening the said clause in that manner as opposed to, for example, starting with the statement that *"abortion is permitted'* and then setting out the circumstances under which it is permitted. We therefore do not accept an interpretation that tends to hold that Article 26(4) means that abortion is legal in this country. To our mind, abortion is not lawful in this country. It stands prohibited as provided under sections 158, 159 and 160 of the **Penal Code** which provide that:

> ***158. Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.***
>
> ***159. Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.***
>
> ***160. Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.***

305. That, however, is not the end of the matter. Article 26(4) proceeds to provide what, in our view, amounts to a proviso or exception to the general rule. Article 26(4) makes an exception to the general rule when it exempts situations in which a trained health professional forms the opinion that there is need for *emergency treatment*, or the *life* or *health* of the mother is in danger, or *if permitted by any other written law*. It is therefore clear beyond doubt that there is a window given to Parliament to legislate situations where abortion is permissible.

306. We are therefore called upon in this petition to consider the situations under which, from the exceptions to the general rule that we have identified above, abortion is permissible in this country. These situations require consideration of the meaning of emergency treatment, situations in which the life or health of the mother is in danger; what 'health' means for purposes of the provisions of Article 26(4); who is qualified to determine that the life or health-however we define it-is in danger, and finally, whether there is a written law in this county that permits abortion.

307. According to the respondents, there is no such law. The petitioners however contend that the law does exist and they cite the 2009 **National Guidelines** which were made pursuant to section 35(3) of the **Sexual Offences Act** which provides that:

> ***Notwithstanding the provisions of sub-section (2), the Minister responsible for health shall prescribe circumstances under which a victim of a sexual offence may at any time access treatment in any public hospital or institution.***

308. The 2009 Guidelines provided that:

> ***"If they [survivors of sexual violence] present with a pregnancy, which they feel is as a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006). If the woman decides to opt for termination, she should be treated with compassion, and referred appropriately."***

309. These Guidelines were however, revised by the 2014 Edition which now provide that:

> ***"If a survivor intends to terminate a pregnancy which resulted from the sexual violence, the health care provider and the survivor should be aware of the Constitutional provision in reference to abortion, thus;***
>
> ***"Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other law (Kenya Constitution 2010)."***

310. Having so noted, we should state at the outset that we do not understand the petitioners to be putting forward the position that abortion is lawful in Kenya under all circumstances or, as the respondents put it, *abortion on demand*. We understand the petitioners to be taking the position that in those circumstances where pregnancy results from sexual violence, as in the case of JMM, should a trained health professional determine that the life or health of the mother is in danger, then the law allows abortion, and that the woman or girl seeking such services should have appropriate care.

311. The respondents have asked the court to determine various issues related to the rights of the unborn child. They ask the court to determine, first, the extent to which the life of the unborn child is protected by Article 26. They further ask the court to determine whether the taking away of the life of an unborn child in Kenya is legal in light of the Constitution and statute law. We have restated above what we believe to be the constitutional position as it emerges from Article 26: that human life begins at conception, and that abortion is prohibited under Article 26(4) and sections 158-160 of the **Penal Code**. However, we recognise that at Article 26(4), the Constitution provides exceptions to the general rule. This is where there is need for emergency treatment or the life or health of the mother is in danger or if permitted by any other written law. These are the considerations we intend to enter into in this petition: the question of what ***"emergency treatment"*** and the ***"life and health of the mother"*** entail, and whether there is ***"any other written law"*** that permits abortion.

312. First, however, we must consider the context in which the petition arises: the situation in which the DMS deemed it necessary to start the process leading to the 2012 Standards and Guidelines, before they were withdrawn in 2013. We take the view that a consideration of the social context in which this petition arises is critical for a proper and informed appreciation of the issues before us. The issues it raises do not arise in a vacuum, but in the lived experiences of the people of Kenya, who voted for the Constitution with the rights and limitations that it contains.

313. This contextual analysis is based on the documents, reports and the evidence that the parties hereto have placed before us. They relate to the incidence of maternal mortality and morbidity that is linked to the women and girls procuring unsafe abortions, and their access to health care as guaranteed under the Constitution.

The Social Context

314. We have considered the various documents that the parties placed before us. One of these documents is a report compiled and launched in 2013 by the **Ministry of Health, African Population and Health Research Center (APHRC), IPAS, and Guttmacher**

Institute. In this report, the Ministry acknowledges that:

> ***"…one missing link in reducing maternal mortality has been the absence of technical and policy guidelines for preventing and managing unsafe abortions to the extent allowed by the Kenyan law" and further, that the continued stigmatization of abortion services makes such services unavailable, leading to poor outcomes, especially for poor and rural-based women who end up dying; whereas affluent women are able to access safe abortion services privately."***

315. In his affidavit sworn on 26th June 2015 in support of the petition, Prof. Japheth Kimanzi Mati averred that the continued lack of access to legal safe abortion services has caused women to resort to illegal, unsafe abortion often resulting in maternal deaths or the women being subjected to lifelong disabilities as a consequence of the unsafe procedures.

316. Anecdotal evidence with respect to the challenge posed by unsafe abortion was given in the affidavits of the 3rd and 4th petitioners. In her affidavit the 3rd petitioner deposed that through her work as a community mobilizer, she has noted with concern the number of women and young girls, left with disabilities as a result of unsafe abortion. She illustrated this experience with incidents in which women who had procured unsafe abortions have died after undergoing unsafe abortions at the hands of unskilled persons within the Mathare community. The 4th petitioner also illustrated the situation of women within her community who have procured abortions at the hands of unskilled persons who have lost their lives as a result, or are suffering lifelong injuries that could have been prevented had they been provided with accurate information and access to reproductive health services.

317. The evidence from the 3rd and 4th petitioners is supported by various reports relied on by the petitioners. In a report prepared by the **Kenya National Commission on Human Rights** titled **"Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya"** published in 2012, it is stated that in the years leading up to the 2009-2010 constitutional reform process, an estimated 2,600 women died annually in Kenya from complications resulting from unsafe abortion.

318. Further, in the **Ministry of Health's Kenya National Post Abortion Care Curriculum: Trainer's Manual (2003)** cited in **Center for Reproductive Rights et. al., In Harm's Way: The Impact of Kenya's Restrictive Abortion Law (2010),** it was indicated that at some point, 35% of maternal deaths in Kenya were said to be attributable to unsafe abortion.

319. A further report relied on by the petitioners also emanated from the Ministry of Health. Titled **"Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study",** it gave the results of a study which was conducted in 2012 and was based on data from a nationally-representative sample of both public and private sector hospitals and health facilities. The report indicates that the study found that Kenya's estimate of 266 deaths per 100,000 unsafe abortions indicates continuing high maternal mortality due to unsafe abortions.

320. The respondents confirmed the rather grim reality of unsafe abortions in the country. In his affidavit sworn on 28th August 2015 on behalf of the respondents, Dr. Muraguri averred that there are approximately 500,000 illegal abortions carried out in Kenya annually. He also averred that Kenya had made least progress in tackling maternal mortality and morbidity, a key cause of which was unsafe abortions. There was therefore a need to tackle such unsafe abortions in order to attain the Millennium Development Goal to reduce maternal mortality

and morbidity and to reduce health costs. Dr. Muraguri further stated that one of the goals of releasing the 2012 Standards and Guidelines was to address a gap in one of the major causes of maternal mortality and morbidity, which was unsafe abortions.

321. Dr. Muraguri's averments and statistics on the incidence of maternal mortality and morbidity as a result of unsafe abortions were confirmed by Dr. Gondi in a Further Replying Affidavit dated 23rd May 2018. Dr. Gondi adopted in his affidavit a "Witness Report" filed on behalf of the 1st, 2nd and 3rd respondents. The report, which he signed, is titled **"The Reviewed Policies, Standards and Guidelines for Reducing Maternal Morbidity and Mortality in Kenya."** Dr. Gondi states in the report that abortion is a global social and public health problem.

322. He refers to a 2012 study done by MOH/APHRC in 2012 (**APHRC, 2013-Incidence and Complications of Unsafe Abortions in Kenya**) in which it is noted that almost half a million induced abortions occurred in Kenya, most of which were unsafe. This was because they were either carried out by persons lacking the necessary skills, in an environment lacking the minimal medical standards, or both. Unsafe abortions, according to Dr. Gondi, contribute to 14% of maternal deaths in Kenya.

323. The respondents thus do not dispute that there is a grave problem arising from unsafe abortions. As both Dr. Muraguri and Dr. Gondi concede, there is a need to establish standards and guidelines for dealing with unsafe abortions.

324. The 2nd and 3rd interested parties do not agree that the situation from unsafe abortion is as dire as the statistics in the reports referred to above show. Dr. Ngare averred on behalf of the 2nd interested party that the data placed before the court in the reports was not reflective of the proper statistics regarding the prevalence of complications which accompany 'unsafe abortion.' Rather, the statistics were estimates based on what Dr. Ngare termed a very controversial, non-scientific, deceptive estimation method that is only used by reproductive health rights groups. However, the Ministry of Health and the DMS are the State entities in charge of the health sector in Kenya. They would be expected to have the correct and accurate information on the state of maternal mortality and morbidity. The interested parties and the respondents do not dispute this. The court is therefore entitled to accept the averments of the DMS as reflective of the correct position on these matters.

325. It is therefore safe to conclude that the social context in which abortion takes place, as emerges from the evidence, is one in which there is a high incidence of sexual violence amongst the poor women and girls. As the 3rd and 4th petitioners illustrate in their affidavits, a large proportion of those who procure abortions in unsafe environments are from the lower echelons of society. While the 2nd interested party's witnesses sought to argue that those who seek abortions are of higher economic status, the reality, which is acknowledged by the Ministry of Health, is that the bulk of those who seek abortion in unsafe environments seek treatment in public health institutions.

326. This was the situation of JMM, who ended up at the Kisii Level 5 hospital, a public referral hospital. Her ordeal presents a classic case of a failed health care system lacking in both skilled staff, facilities and a proper referral system. Here is a case of a 14 year old minor, who gets pregnant as a result of defilement. She does not have any information about where to seek help. She winds up in the hands of a "quack" who, from all appearances, had no skills or training to undertake abortion. She ends up in a dispensary which also appeared not to have had qualified staff and facilities. She was referred to Kisii Level 5 Hospital where, if we are to believe the DMS, JMM should have received effective, high quality and appropriate treatment. In the words of the DMS, there would be qualified doctors and facilities to provide

post abortal care but that was not the case. Part of the foetus was removed and she was left with excessive bleeding. Her kidneys started failing due to haemorrhagic shock. She required dialysis. They did not have a dialysis machine and instead of referring her to a public institution with appropriate facilities, they discharged her in that condition and suggested to her to go to Tenwek Hospital without caring to find out whether it had a dialysis machine. They did not offer an ambulance. Instead, they asked her to pay Kshs 12,500.00 for the ambulance. Her mother, PKM, did not have. She however, managed to take her to Tenwek where they found there was no dialysis machine. She eventually ended up at Kenyatta National Hospital when it was too late to save her life.

327. Her situation illustrates the need for training to impart the requisite skills and knowledge and create an environment in which the incidence of maternal deaths as a result of unsafe abortions can be addressed. This need is recognised by both the petitioners and the respondents. For instance, the Ministry of Health in its National Reproductive Health Training Plan, 2007-2012 NRHTP, stated that the mission of the health sector in Kenya is to promote and participate in the provision of integrated and high quality curative, preventive and rehabilitative health care service. The Ministry of Health acknowledges the need to have skilled health care workers. It further acknowledges that in order for this to be achieved more investments must be made in competency based training both during pre-service and in-service to ensure proficiency in reproductive health skills.

328. It is apparent therefore that there is a need to address the challenge posed by unsafe abortion in Kenya. To do otherwise, so argue the petitioners, is to leave women and girls such as JMM, without recourse to information on safe services, and is a violation of their rights under the Constitution and international instruments that protect their human rights. It is thus important to consider at this point the constitutional rights implicated in this petition before considering whether the actions of the respondents had the effect of violating these rights.

Constitutional Rights implicated in the Petition.

329. The case of the petitioners is that the Ministry of Health, in promulgating the 2012 Standards and Guidelines, sought to manage all the aspects of prevention of unsafe abortion using the multi-sectoral approach. They argue that the 2012 Standards and Guidelines addressed issues related to prevention and management of unintended, risky and unplanned pregnancies, post abortion care and standards for monitoring and audit. Further, that the recommendations stuck to the laws as set out in the Constitution, Acts of Parliament and other legal instruments.

330. In addition, it is their contention that the 2012 Standards and Guidelines adhered to proven scientific recommendations and were developed in a process that involved a wide range of stakeholders, including representatives from the medical profession, religious sector, development partners and civil society organisations. However, the 2012 Standards and Guidelines were withdrawn by the DMS through his letter dated 3rd December 2013, and the training curriculum was also withdrawn by the Memo dated 24th February 2014. The Memo also threatened professional and legal sanctions for those health care professionals who attended trainings on safe abortion practices and the use of Medabon.

331. The petitioners argue that the Memo and letter negate the spirit and letter of the Constitution, which aim to protect the health and lives of women and girls in Kenya. The withdrawal of the 2012 Standards and Guidelines threaten to reverse gains made in curtailing maternal deaths due to unsafe abortions. The petitioners attribute the predicament of JMM and her eventual death to the actions of the DMS, contending that presumably as a result of lack of information on how to respond to or whom to approach after being subjected to

sexual violence, she was not able to receive immediate post-rape care, including emergency contraceptive and post exposure prophylaxis. She had upon realising she was pregnant, been taken to an untrained person who performed an unsafe abortion. We have already set out elsewhere in this judgment the chain of events that eventually led to the death of JMM.

332. The petitioners argue that by withdrawing the 2012 Standards and Guidelines and issuing the Memo, the DMS undermined various constitutional rights guaranteed to women under the Constitution. These are the rights of women and girls to life under Article 26(1), the right to health, which includes the right to reproductive health under Article 43(1)(a)); the right to equality and non-discrimination guaranteed under Article 27 and the right to dignity under Article 28. They also allege violation of the right to freedom from cruel, inhuman and degrading treatment guaranteed under Article 29(f)).

333. It is also the petitioners' case that the withdrawal of the 2012 Standards and Guidelines violates the petitioners' right to access information under Article 35(1)(b), including health-related information by depriving them access to potentially life-saving medical information and services and enjoying the benefits of scientific progress, and the right to freedom of expression under Article 33. The petitioners also contend that the actions of the DMS violate the constitutional and international human rights of healthcare providers to information, training and education, as well as the right to enjoy the benefits of scientific progress. It is their view that this has the effect of impacting health care providers' core obligation to provide safe, quality health services, such as legally mandated abortions and post abortal care. It is also contended that the actions of the DMS violated the provisions of Article 47 that guarantees to all the right to fair administrative action. In the petitioners' view, the actions of the DMS have the effect of limiting rights in a manner that is not in accord with Article 24.

334. We have already set out elsewhere above the provisions of Article 26(1), which guarantees to everyone the right to life. This right is also guaranteed under international conventions to which Kenya is a party and which are, in accordance with Article 2(5) and (6) part of Kenyan law. In this regard, see Article 6 of the ICCPR and Article 3 of the UDHR. Article 1 and 2 of CEDAW guarantee to women enjoyment of all human rights on an equal basis with men.

335. The right to life and the right to health are at the core of this petition. Article 43 (1) provides that ***"Every person has the right—(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care."***

336. The term 'health' is defined by the World Health Organisation as ***"a state of complete physical, mental and social well-being, and is not only the absence of disease or infirmity."*** This is also the definition of health contained in the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.**

337. The inter-linkage and inter-dependence of rights is recognised, and in this regard, the right to health is an underlying determinant of the enjoyment of other rights. In **Purohit & Moore v The Gambia Communication 241/01** the African Commission stated, at paragraph 80 that:

> ***"Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms. This right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind."***

338. In his decision in **Mathew Okwanda v. Minister of Health and Medical Services & 3 others [2013] eKLR**, Majanja J stated that:

> ***"The General Comment [Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14] recognises that the right to health is closely related to the economic rights and is dependent on the realization of the other rights including the rights to food, housing, water, work, education, human dignity, life, non-discrimination, equality, prohibition of torture, privacy, access to information and other freedoms."***

339. The Court in **P.A.O & 2 Others v Attorney General [2012] eKLR** adopted the definition of health in **General Comment No. 14 on the Right to Health** in which the Committee on Economic, Social and Cultural Rights notes that:

> ***'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.'***

340. In addition, with respect to women and girls, the right to health under the Constitution encompasses the right to ***'reproductive health care'***. It is noted at General Comment No. 14 of the **ICESR** at paragraph 14 that:

> ***"14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care emergency obstetric services and access to information, as well as to resources necessary to act on that information."***

341. With respect to the right to health of women, the **International Conference on Population and Development Program of Action 1994**, paragraph 7.2 defined the right to health as follows:

> ***"a state of complete 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. Reproductive health therefore implies that people are able to have a satisfying 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."***

342. Aside from guaranteeing the rights set out in the Bill of Rights, the Constitution imposes on the state obligations with respect to the enjoyment by citizens of these rights. Article 19 provides that:

> ***(1) The Bill of Rights is an integral part of Kenya's democratic state and is the framework for social, economic and cultural policies.***
>
> ***(2) The purpose of recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings.***
>
> ***(3) The rights and fundamental freedoms in the Bill of Rights—***
>
> ***(a) belong to each individual and are not granted by the State;***

(b) do not exclude other rights and fundamental freedoms not in the Bill of Rights, but recognised or conferred by law, except to the extent that they are inconsistent with this Chapter; and

(c) are subject only to the limitations contemplated in this Constitution.

343. Article 21 provides that:

(1) It is a fundamental duty of the State and every State organ to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights.

(2) The State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed under Article 43.

344. It is thus evident that women and girls, as contended by the petitioners, have rights, in common with every other citizen, guaranteed to them under the Constitution. However, because of their sex, they are also guaranteed rights that are specific to them, the reproductive rights guaranteed under Article 43 (1) (a) of the Constitution. Since the state has an obligation under Article 21(1) to **"observe, respect, protect, promote and fulfil"** the rights guaranteed under the Bill of Rights, and to ***"take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed under Article 43",*** then any action that limits or diminishes this right is a violation of the Constitution. The petitioners argue that by withdrawing the 2012 Standards and Guidelines and Training Curriculum, the Respondents violated the Constitution. We now turn to consider the principles against which we measure the constitutionality or otherwise of the actions of the DMS.

Applicable Constitutional Principles

345. In making the determination in this regard, we are guided by certain principles which have been applied with regard to interpretation of questions on the constitutionality of actions taken by state organs. We bear in mind, first, the provisions of Article 20 which provides that:

(1) The Bill of Rights applies to all law and binds all State organs and all persons.

(2) Every person shall enjoy the rights and fundamental freedoms in the Bill of Rights to the greatest extent consistent with the nature of the right or fundamental freedom.

(3) In applying a provision of the Bill of Rights, a court shall—

(a) develop the law to the extent that it does not give effect to a right or fundamental freedom; and

(b) adopt the interpretation that most favours the enforcement of a right or fundamental freedom. [Emphasis added]

346. In its decision in **Coalition for Reform and Democracy (CORD) & 2 others v Republic of Kenya &10; others [2015] eKLR** the Court set out succinctly the principles that a court should bear in mind when interpreting the Constitution. We can do no better than to set out the words of the Court:

"91. The Constitution has given guidance on how it is to be interpreted. Article 259 thereof requires that the Court, in considering the constitutionality of any issue before it, interprets the Constitution in a manner that promotes its purposes, values

and principles, advances the rule of law, human rights and fundamental freedoms in the Bill of Rights and that contributes to good governance.

92. We are also guided by the provisions of Article 159(2) (e) of the Constitution which require the Court, in exercising judicial authority, to do so in a manner that protects and promotes the purpose and principles of the Constitution.

93. Thirdly, in interpreting the Constitution, we are enjoined to give it a liberal purposive interpretation. At paragraph 51 of its decision in ***Re The Matter of the Interim Independent Electoral Commission Constitutional Application No 2 of 2011****, the Supreme Court of Kenya adopted the words of Mohamed A J in the Namibian case of* ***S. vs Acheson, 1991 (2) S.A. 805*** *(at p.813) where he stated that:*

"The Constitution of a nation is not simply a statute which mechanically defines the structures of government and the relationship between the government and the governed. It is a 'mirror reflecting the national soul'; the identification of ideals and ….aspirations of a nation; the articulation of the values bonding its people and disciplining its government. The spirit and the tenor of the Constitution must, therefore, preside and permeate the processes of judicial interpretation and judicial discretion."

94. Further, the Court is required, in interpreting the Constitution, to be guided by the principle that the provisions of the Constitution must be read as an integrated whole, without any one particular provision destroying the other but each sustaining the other: see ***Tinyefuza vs Attorney General of Uganda Constitutional Petition No. 1 of 1997 (1997 UGCC 3)****.*

347. We are also guided by the words of the Court in **Re Kadhis' Court: The Very Right Rev Dr. Jesse Kamau & Others vs The Hon. Attorney General & Another Nairobi HCMCA No. 890 of 2004**. While dealing with the question of interpretation in a matter predating the present Constitution, the court expressed the following view with respect to interpretation of the Constitution, particularly in relation to the Bill of Rights:

> ***"The general provisions governing constitutional interpretation are that in interpreting the Constitution, the Court would be guided by the general principles that; (i) the Constitution was a living instrument with a soul and consciousness of its own as reflected in the preamble and fundamental objectives and directive principles of state policy. Courts must therefore endeavour to avoid crippling it by construing it technically or in a narrow spirit. It must be construed in tune with the lofty purposes for which its makers framed it. So construed, the instrument becomes a solid foundation of democracy and the rule of law. A timorous and unimaginative exercise of judicial power of constitutional interpretation leaves the Constitution a stale and sterile document; (ii) the provisions touching fundamental rights have to be interpreted in a broad and liberal manner, thereby jealously protecting and developing the dimensions of those rights and ensuring that our people enjoy their rights, our young democracy not only functions but also grows, and the will and dominant aspirations of the people prevail. Restrictions on fundamental rights must be strictly construed."*** [Emphasis added].

348. Finally, it is apposite at this point to consider the provisions of Article 24 of the Constitution, which sets out the parameters with respect to limitation of rights. This is in recognition of the fact that, with the exception of the rights set out in Article 25, all other rights may be limited in the circumstances prescribed under Article 24. This Article provides that:

1) ***A right or fundamental freedom in the Bill of Rights shall not be limited except by law, and then only to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—***

a) the nature of the right or fundamental freedom;

(b) the importance of the purpose of the limitation;

(c) the nature and extent of the limitation;

(d) the need to ensure that the enjoyment of rights and fundamental freedoms by any individual does not prejudice the rights and fundamental freedoms of others; and

(e) the relation between the limitation and its purpose and whether there are less restrictive means to achieve the purpose.

2) ***Despite clause (1), a provision in legislation limiting a right or fundamental freedom—***

(a) in the case of a provision enacted or amended on or after the effective date, is not valid unless the legislation specifically expresses the intention to limit that right or fundamental freedom, and the nature and extent of the limitation;

(b) shall not be construed as limiting the right or fundamental freedom unless the provision is clear and specific about the right or freedom to be limited and the nature and extent of the limitation; and

(c) shall not limit the right or fundamental freedom so far as to derogate from its core or essential content.

3) ***The State or a person seeking to justify a particular limitation shall demonstrate to the court, tribunal or other authority that the requirements of this Article have been satisfied.***

4) ***The provisions of this Chapter on equality shall be qualified to the extent strictly necessary for the application of Muslim law before the Kadhis' courts, to persons who profess the Muslim religion, in matters relating to personal status, marriage, divorce and inheritance.***

349. These provisions reflect what has emerged from judicial precedents which are persuasive in nature-see **R vs Oakes (1986) ISCR 103.** The limitation of rights must, first, be by law, and secondly, the objective of the law must be pressing and substantial and must be important to society -see **R vs Big Drug Mart Ltd (1985) ISCR 295.**

350. The third principle is that of proportionality-whether the state, in seeking to achieve its objectives, has chosen a proportionate way to achieve the objectives that it seeks to achieve. The question to consider in this regard is whether the legislation meets the test of proportionality relative to the objects or purpose it seeks to achieve: see **R vs Chaulk (1990) 3SCR 1303.**

351. In considering the test of reasonableness and proportionality set out in the **Oakes** case, Emukule J, in his decision in **Martha Karua v Radio Africa Ltd t/a Kiss F.M. Station & 2 others [2006] eKLR** observed as follows:

"On the issue of reasonableness in relation to the limitation we fully approve and endorse the reasoning in the Canadian case of R v OAKES (1986) 26 DLR 4TH 200. One of the principles in the case concerning reasonableness of the limitation is that the interest underlying the limitation must be of sufficient importance to outweigh the constitutionally protected right and the means must be proportional to the object of the limitation. Our interpretation of the use of reasonableness in the limitation clause is that since what is at stake is the limitation of fundamental rights, that must mean the legislative objective of the limitation law must be motivated by substantial as opposed to trivial concerns and directed towards goals in harmony with the values underlying a democratic society."

352. With respect to the question of proportionality, Emukule J expressed the view that:

"[The] Proportionality test requires the following of any limitation:

(a) that it be rationally connected to its objective,

(b) that it impairs the right or freedom as little as possible and

(c) that there is proportionality between its effects and its objectives – see OAKES case (supra).

353. We are duly guided by the constitutional provisions and judicial pronouncements set out above, and we now turn to consider the substantive issues raised in this petition.

Abortion under the Constitution

354. We observed elsewhere in this judgment that in our view, while Article 26(2) contains a prohibition of abortion, it contains the general rule. Article 26(4) sets out the exception to the general rule:

(4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

355. There is some consensus, albeit limited, between the opposing parties to this petition that the above provisions allow a window for abortions in Kenya. The petitioners seek a liberal, wider interpretation of the provision, while the interested parties who oppose the petition allow for a mere chink- only when the life of the mother is in absolutely dire straits, for the life of the unborn child must be secured, in the words of Dr. Stephen Karanja, at all costs. The position of the respondents is somewhat ambiguous on the issue. As emerges from the averments of Dr. Muraguri and Dr. Gondi, the respondents recognise the challenge posed by unsafe abortions that results from lack of a clear framework for ensuring that women have access to safe reproductive health care and post abortal services, have issued guidelines in the past with regard to such access, but appear to be somewhat intimidated by the objection from other sectors, particularly from the faith based sectors, to such initiatives.

356. In our view, the constitutional provisions with respect to abortion in a situation in which emergency treatment is required, or where the life of the mother is in danger, are not disputable. Section 2 of the **Health Act, No. 21 of 2017**, defines *'emergency treatment'* as follows:

"emergency treatment" *refers to necessary immediate health care that must be administered to prevent death or worsening of a medical situation;*

357. The 2nd and 3rd interested parties have argued that this determination on whether or not an abortion should be permitted can only be based on the opinion of a **"trained health professional"** which in their view means a 'qualified medical doctor.' However, section 6(1) and (2) of the **Health Act 2017** provides as follows:

> ***(1) Every person has a right to reproductive health care which includes—***
>
> ***(a) the right of men and women of reproductive age to be informed about, and to have access to reproductive health services including to safe, effective, affordable and acceptable family planning services;***
>
> ***(b) the right of access to appropriate health-care services that will enable parents to go safely through pregnancy, childbirth, and the postpartum period, and provide parents with the best chance of having a healthy infant;***
>
> ***(c) access to treatment by a trained health professional for conditions occurring during pregnancy including abnormal pregnancy conditions, such as ectopic, abdominal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened. All such cases shall be regarded as comprising notifiable conditions.***
>
> ***(2) For the purposes of subsection (1)(c), the term "a trained health professional" shall refer to a health professional with formal medical training at the proficiency level of a medical officer, a nurse, midwife, or a clinical officer who has been educated and trained to proficiency in the skills needed to manage pregnancy-related complications in women, and who has a valid license from the recognized regulatory authorities to carry out that procedure.***

358. One may ask why the Constitution, which was approved in a referendum by 67% of the people of Kenya, deemed it fit to use the term 'trained health professional' instead of 'a medical doctor' as contended by the 2nd and 3rd interested parties. In our view, this was a concession to the dearth of qualified medical doctors in many of our health facilities. As emerged in the course of the hearing of this petition, many of the first line health facilities to which women and girls in need of reproductive health services go to are manned by nurses and clinical officers. We take the view therefore that this contention by the interested parties is not borne out by the constitutional and statutory provisions, or by the reality on the ground. As was recognised in the Constitution making process as contained in the ***Final Report of the Committee of Experts on Constitutional Review:***

> ***"The requirement that abortion could be performed by medical practitioners alone also raised concerns. It would mean that women in poor rural communities without such services would be unable to procure abortions with potentially serious or fatal repercussions for some poor women. There was also need to ensure that the language used by the PSC did not outlaw methods of fertility control, such as emergency contraception. The CoE accordingly amended the draft to include language that would enable appropriate medical intervention to be available when necessary."***

359. What about the **'health'** of the mother, the risk to which should allow for an abortion? The petitioners argue that this term should be read to include both physical and mental health. The respondents argue for an interpretation that covers only physical health.

360. The Constitution does not define the term 'health'. However, the **Health Act** defines it, in words that replicate the WHO definition as follows:

> ***"health" refers to a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;***

361. WHO also defines health to include both physical and mental health:

> ***"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."***

362. In our view therefore, the Constitution permits abortion in situations where a pregnancy, in the ***opinion of a trained health professional***, endangers the life or **mental** or **psychological** or **physical** health of the mother.

363. A third exception to the prohibition of abortion under the Constitution is where abortion is permitted by ***"any other written law"***.

364. The question is whether there was *'any other written law'* that permitted abortion and on the basis of which the withdrawn 2012 Standards and Guidelines had been issued, or which predated the Guidelines and permitted abortion in certain circumstances.

365. The petitioners argued that abortion is lawful when it is permitted by a statute, treaty or convention, a view reflected also in the submissions of the 1st *Amicus Curiae.* It is further contended that section 35(3) of the **Sexual Offences Act No. 3 of 2006** provides for such a situation. The section provides that ***"[the] Minister responsible for Health shall prescribe circumstances under which a victim of a sexual offence may at any time access treatment in any public hospital or institution"***. In guidelines promulgated by the Ministry of Health in 2009 titled **'National Guidelines on the Management of Sexual Violence in Kenya, 2nd Edition, 2009'**, it was provided that:

> ***"if [survivors of sexual violence] present with a pregnancy, which they feel is as a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006)"***.

366. The respondents argue that the 2009 Guidelines are not 'any other written law' as provided under Article 26(4). Their position is that the only law in force with respect to abortion is the **Penal Code**, whose provisions we have set out earlier in this judgement.

367. We make two observations with respect to these two Acts of Parliament that have a bearing on the question of abortion. First, it is correct that the **Penal Code** prohibits abortion. However, it is an Act of Parliament that predates the **Sexual Offences Act, 2006**, and the Constitution. The provisions of the **Sexual Offences Act** which is later in time takes precedence. We take this view bearing in mind the doctrine of implied repeal, under which, if the provisions of an Act are inconsistent with the provisions of an earlier Act, the earlier provisions may be impliedly repealed by the later legislation-see **Bennion on Statutory interpretation, Section 6.10: Implied repeal.** Bennion states as follows with respect to implied repeal:

> ***"The classic statement of the test for implied repeal was set out by A L Smith J in West Ham (Churchwardens, etc) v***
>
> ***Fourth City Mutual Building Society:3***
>
> ***"The test of whether there has been a repeal by implication by subsequent legislation is this: are the provisions of a later Act so inconsistent with, or repugnant to, the provisions of an earlier act that the two cannot stand together?"***

368. Mativo J considered this principle in his decision in **A O O & 6 others v Attorney General & another [2017] eKLR** in which he observed as follows:

> ***"The Children's Act (sic) came into effect on 1st March, 2002. The Penal Code's[54] commencement date was 1st August, 1930. According to principles of construction if the provisions of a later Act are so inconsistent with or repugnant to those of an earlier Act that the two cannot stand together, the earlier Act stands impliedly repealed by the latter Act. It is immaterial whether both Acts are Penal Acts or both refer to Civil Rights. The former must be taken to be repealed by implication.[55] This principle was properly adopted in Martin Wanderi & 19 others vs. Engineers Registration Board of Kenya & 5 Others,[56] where the Court, rendered itself as follows:-***
>
> ***"This is because of the canons of interpretation with regard to the timing of legislation, and the doctrine of implied repeal, which is to the effect that where provisions of one Act of Parliament are inconsistent or repugnant to the provisions of an earlier Act, the later Act abrogates the inconsistency in the earlier one…."*** (Footnotes omitted).

369. More importantly, the Constitution having provided a right to abortion where, in the opinion of a trained health professional there is need for emergency treatment, or that the life or health of the mother is in danger, the apparent blanket prohibition of abortion under the **Penal Code** cannot stand. This is because, in accordance with sections 6 and 7 of the 6th Schedule to the Constitution, the provisions of the **Penal Code** must be read with the necessary ***"alterations, adaptations, qualifications and exceptions"*** to bring it into conformity with the Constitution. While the said section is still valid in so far as unlawful abortions are concerned, the same must be read taking into consideration the provisions of the Constitution as well as the Sexual Offences Act. We associate ourselves with the opinion in **Steve Thoburn vs. Sunderland City Council 2002 EWHC 195** where the court stated as follows:

> ***"… [42] "… [I]f they [the two statutes] are inconsistent to that extent [viz. so that they cannot stand together], then the earlier Act is impliedly repealed by the later in accordance with the maxim 'Leges posteriores priores contrarias abrogant'… Authority to the effect that the doctrine of implied repeal may operate in this limited fashion is to be found in Goodwin v Phillips [1908] 7 CLR 1, in the High Court of Australia, in which Griffith CJ stated at 7: "… if the provisions are not wholly inconsistent, but may become inconsistent in their application to particular cases, then to that extent the provisions of the former Act are excepted or their operation is excluded with respect to cases falling within the provisions of the later Act."***

370. In this case, paragraph 2 of the First Schedule to the Sexual Offences Act expressly provides as follows:

> ***For greater certainty, the provisions of this Act shall supersede any existing provisions of any other law with respect to sexual offences.***

371. It thus appears to us that under the Constitution and the ***Sexual Offences Act***, while the general rule is that abortion is prohibited, it is permissible in the circumstances prescribed under Article 26(4), and further as provided under section 35(3) of the **Sexual Offences Act**. The 2009 Guidelines issued by the Minister in accordance with the **Sexual Offences Act** had provided that victims of sexual violence who became pregnant as a result should be informed that termination of pregnancy may be allowed after rape, and should they opt for termination, should be treated with compassion, and referred appropriately.

372. In our view therefore, women and girls in Kenya who find themselves pregnant as a result of sexual violence have a right, under Kenyan law, to have an abortion performed by a trained health professional if that health professional forms the opinion that the life or health of the mother is in danger. Health, in our view, encompasses both physical and mental health. While Kenya made a reservation to Article 14 (2)(c) of the Maputo Protocol, it is instructive that the words of the Article mirror in some respects the words used in the Constitution:

> "***Article 14.2 c): the right to safe abortion in cases of sexual assault, rape, incest and when the pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."***

373. Further, Kenya is also a signatory to the **International Covenant on the Elimination of all Forms of Discrimination against Women**. In its recommendations adopted after its 11th General Session in 1992, the Committee requires States to, among other things, enact and enforce laws and policies that protect women and girls from violence and abuse and provide for appropriate physical and mental health services. It also requires that health-care workers should also be trained to detect and manage the health consequences of violence against women.

374. In our view, there can be no dispute that sexual violence exacts a major and unacceptable toll on the mental health of women and girls. Whether the violence occurs in the home or in situations of conflict, women suffer unspeakable torment as a result of such violence.

375. In his decision in **C. K. (suing through Ripples International as her guardian & next friend) & 11 others v Commissioner of Police / Inspector General of the National Police Service & 3 Others (2013) eKLR Makau J** found that sexual violence had a profound effect on the health, both physical and mental, of the survivors of such violence. He observed as follows:

> ***"I further find that the petitioners in this petition have suffered horrible, unspeakable and immeasurable harm due to acts of defilement committed against them. They each suffered physical harm in the form of internal and external wounds from the perpetrators assaults and some suffered consequences of unwanted pregnancies vested (sic) on children not physically mature enough to bear children. The petitioners have suffered psychological harm from assaults made worse by the threat, fear and reality of contracting HIV/AIDS and other sexually transmitted diseases or infections."***

376. As submitted by the 1st *Amicus Curiae*, in reliance on the provisions of Maputo Protocol, General Comment No. 2:

> ***"The Protocol provides for women's right to terminate pregnancies contracted following sexual assault, rape and incest. Forcing a woman to keep a pregnancy resulting from these cases constitutes additional trauma which affects her physical and mental health … Apart from the potential physical injuries in the short and long term, the unavailability or refusal of access to safe abortion services is often the cause of mental suffering, which can be exacerbated by the disability or precarious socioeconomic status of the woman."***

377. We bear this in mind as we turn to consider the question whether the withdrawal of the 2012 Standards and Guidelines and the Memo of the DMS violated the constitutional rights of women and girls under the Articles of the Constitution earlier mentioned.

The Promulgation and Withdrawal of the Standards and Guidelines

378. As we observed earlier, the state, represented in this petition by the respondents, and in particular by the DMS, had an obligation to ensure the enjoyment by women and girls of the rights under Article 26(4) and 43(1)(a). As averred by Dr. Muraguri and confirmed by Dr. Gondi, the state had taken the initiative and set up a Technical Working Group that was consultative in nature. This Working Group came up with the 2012 Standards and Guidelines that are the subject of this petition. However, the 2012 Standards and Guidelines were withdrawn by the letter dated 3rd December 2013. The DMS had followed up the letter with the Memo of 24th February 2014 in which he had threatened dire legal and professional consequences for those who undertook training on safe abortion. As submitted by the petitioners, the withdrawal of the 2012 Standards and Guidelines was done unilaterally by the DMS.

379. The petitioners submit that the withdrawal was in violation of their rights and the rights of women and girls such as JMM to fair administrative action under Article 47; to non-discrimination under Article 27; to dignity under Article 28; right to information under Article 35 and most importantly, as in the case of JMM, the right to life. They view the withdrawal of the 2012 Guidelines and Standards and the Training Curriculum as having led to confusion and lack of clarity on the part of health care providers as to when an abortion is permissible under the law. The DMS had compounded the problem by asserting that abortion is illegal in Kenya, without due regard to the permissible grounds under the Constitution.

380. The respondents support the withdrawal of the 2012 Standards and Guidelines, as well as the Training Curriculum. They argue that the 2012 Standards and Guidelines had included matters that had not been agreed upon in the Technical Working Group. While the 2nd interested party had initially alleged that it had not been part of the group that developed the 2012 Standards and Guidelines, it conceded later that this was not the case. Rather, certain items that had not been the subject of consensus had been included in the 2012 Standards and Guidelines.

381. Article 10 of the Constitution provides as follows:

(1) The national values and principles of governance in this Article bind all State organs, State officers, public officers and all persons whenever any of them—

> ***(a) applies or interprets this Constitution;***
>
> ***(b) enacts, applies or interprets any law; or***
>
> ***(c) makes or implements public policy decisions.***
>
> ***(2) The national values and principles of governance include—***
>
> ***(a) patriotism, national unity, sharing and devolution of power, the rule of law, democracy and participation of the people;***

382. Apart from anything else it is clear that the 2012 Standards and Guidelines and the Training Curriculum were public policy documents. It is also clear that they were the product of a public participatory process as required under the Constitution. Their withdrawal however did not follow the same process. In other words, they were arbitrarily withdrawn. To our mind a decision to withdraw a public policy document must similarly be subjected to the constitutional dictates. It is a power that cannot therefore be arbitrarily exercised. It is now recognised that arbitrary exercise of power, even where it exists, is a ground to grant a judicial review relief which is one of the reliefs under Article 23(3) of the Constitution.

383. The question however, is whether the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum was lawful. Article 43(1) (a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

384. Abortion in constitutionally permissible circumstances is clearly a right since as we have stated above, Article 26 of the Constitution falls under the Bill of Rights. The arbitrary withdrawal of the 2012 Guidelines and Training Curriculum clearly left those to whom the rights thereunder are bestowed, women and girls to the vagaries of medical quacks and backstreet services. In our view, their withdrawal amounted to a limitation of the said right.

385. Article 24 (1) permits limitation of rights only to the extent that it is reasonable and justifiable in a democratic society. The phrase 'justifiable in an open and democratic society' was dealt with in **Obbo and Another vs. Attorney General [2004] 1 EA 265** in which the court expressed itself as follows:

> ***"It is not correct that the test of what is acceptable and demonstrably justifiable for the purposes of limitation imposed on the freedoms of expression and freedom of the press in a free and democratic society must be a subjective one. The test must conform with what is universally accepted to be a democratic society since there can be no varying classes of democratic societies for the following reasons:- (i). First Uganda is a party to several international treaties on fundamental and human rights, and freedoms all of which provide for universal application of those rights and freedoms and the principles of democracy. The African Charter for Human and Peoples Rights and the International Covenant on Civil and Political Rights are only two examples. (ii). Secondly, the preamble to the Constitution recalls the history of Uganda as characterised by political and constitutional instability: recognises the people's struggle against tyranny, oppression and exploitation and says that the people of Uganda are committed to building a better future by establishing through a popular and durable constitution based on the principles of unity, peace, equality, democracy, freedom, social justice and progress. When the framers of the Constitution committed the people of Uganda to building a democratic society, they did not mean democracy according to the standard of Uganda with all that it entails but they meant democracy as universally known...It is a universally acceptable practice that cases decided by the highest courts in the jurisdictions with similar legal systems which bear on a particular case under consideration may not be binding but are of persuasive value, and are usually followed unless there are special reasons for not doing so."***

386. As regards the limitation in **R vs. Oakes [1986] 1 SCR 103,** it was held that:

> ***"Firstly the objective to be served by the measures limiting a Charter right must be sufficiently important to warrant overriding a constitutionally protected right or freedom. The standard must be high to ensure that trivial objectives or those discordant with the principles of a free and democratic society do not gain protection. At a minimum, an objective must relate to societal concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important. Second, the party invoking s. 1 must show the means to be reasonable and demonstrably justified. This involves a form of proportionality test involving three important components. To begin, the measures must be fair and not arbitrary, carefully designed to achieve the objective in question and rationally connected to that objective. In addition, the means should***

impair the right in question as little as possible. Lastly, there must be a proportionality between the effects of the limiting measure and the objective the more severe the deleterious effects of a measure, the more important the objective must be."

387. International human rights bodies have developed a detailed guidance on how the restrictions on the right can be applied and to meet the so called the 'three part test' described below.

388. First, the restrictions must be prescribed by law: this means that a norm must be formulated with sufficient precision to enable an individual to regulate his or her conduct accordingly (see, Human Rights Committee, *Leonardus J.M. de Groot v. The Netherlands, No. 578/1994, U.N. Doc. CCPR/C/54/D/578/1994 (1995)*.

389. Second, restrictions must pursue a legitimate aim, exhaustively enumerated in Article 19(3) (a) and (b) of the ICCPR as respect of the rights or reputations of others, protection of national security, public order, public health or morals.

390. Third, restrictions must be necessary and proportionate to secure the legitimate aim: Necessity requires that there must be a pressing social need for the restriction. The party invoking the restriction must show a direct and immediate connection between the expression/information and the protected interest. However, we have shown that the premise of the Memo was misguided and thus not necessary.

391. In this case the limitation was a negative act of arbitrary withdrawal of the facilitating instruments. No back up mechanisms was put into place to facilitate the said rights in the absence of the said 2012 Standards and Guidelines and Training Curriculum. The 2014 Guidelines, apart from drawing attention to the constitutional provisions did not guide the health professionals on the circumstances in which the said rights were to be attained. In our view the 2014 Guidelines did not meet the threshold of precision required under Article 24.

392. To the extent that the withdrawal was by the DMS as opposed to the Medical Practitioners and Dentists Board, the act itself was *ultra vires* and unlawful. This position is restated in section 7(2)(a)(i)(ii) and (iii) of the ***Fair Administrative Action Act, 2015*** where it is provided that a court or tribunal may review an administrative action or decision, if the person who made the decision was not authorized to do so by the empowering provision; acted in excess of jurisdiction or power conferred under any written law; or acted pursuant to delegated power in contravention of any law prohibiting such delegation. In **Hardware & Ironmonery (K) Ltd Vs. Attorney-General Civil Appeal No. 5 of 1972 [1972] EA 271,** the Court expressed itself as follows:

"There is no absolute rule governing the question of delegation, but in general, where a power is discretionary and may affect substantial rights, a power of delegation will not be inferred, although it might be in matters of a routine nature. The decision whether or not the licence should be revoked required the exercise of discretion in a matter of greatest importance, since it involved weighing the national interest against a grave injustice to an individual. It was clearly a decision to be taken only by a very senior officer and was not one in respect of which a power of delegation could be inferred."

393. **Lord Somervel** in **Vine vs. National Doc Labour Board [1956] 3 All ER 939**, at page 951 held that:

> ***"The question in the present case is not whether the local board failed to act judicially in some respect in which the rules of judicial procedure would apply to them. They failed to act at all unless they had power to delegate. In deciding whether a person has power to delegate, one has to consider the nature of the duty and the character of the person. Judicial authority normally cannot, of course, be delegated…There are on the other hand many administrative duties which cannot be delegated. Appointment to an office or position is plainly an administrative act. If under a statute a duty to appoint is placed on the holder of an office, whether under Crown or not, he would normally, have no authority to delegate. He could take advice, of course, but he could not, by a minute authorise someone else to make the appointment without further reference to him. I am however, clear that the disciplinary powers, whether "judicial" or not, cannot be delegated."***

394. That is also our understanding of the holding in **Pastoli vs. Kabale District Local Government Council and Others [2008] 2 EA 300.** In this case there is no evidence that the Board made the decision to withdraw the said documents. There is, however, no express power to delegate and we refuse to make such inference.

395. Accordingly, the limitation was not by law. Further, the said action neither specifically expressed the intention to limit that right or fundamental freedom, and the nature and extent of the limitation was not clear and specific about the right or freedom to be limited and the nature and extent of the limitation. In addition, it is our view that considering relation between the limitation and its purpose and whether there are less restrictive means to achieve the purpose, the limitation did not meet the proportionality test. The state, which under Article 24(3) of the Constitution shoulders the burden of demonstrating that the requirements of this Article has been satisfied has failed to do so. If the only issue was the misuse of otherwise useful 2012 Standards and Guidelines and Training Curriculum, we have not been satisfied that there are not available mechanisms to stop the same otherwise by withdrawal of the said instruments. The withdrawal of the 2012 Standards and Guideline and the Training Curriculum was unreasonable, drastic and unjustifiable in a democratic society.

Conclusion

396. We have dealt in the preceding sections with the issues, which were raised before us in this petition. What remains is to summarise our findings on the issues which we identified hereinabove and our disposition of the petition.

397. As regards the issue whether Article 26(4) permits abortion in certain circumstances, the difference in the opinions held by the petitioners and the respondents, in our view is related to form than substance. While the respondents contend that abortion is illegal, the petitioners contend that abortion is permissible. As we have stated hereinabove, the general rule is that abortion is illegal. However, abortion is permissible, if in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law. That is the letter of the Constitution and that is our view.

398. The second issue is whether pregnancy resulting from sexual violence falls under the permissible circumstances for abortion under Article 26(4). This issue is intertwined with the question whether rape and defilement are some of the legal grounds for termination of pregnancy in Kenya are permissible under Article 26(4). This issue cannot however be dealt with without determining the issues relating to right to health and the right to reproductive health. Health in section 2 of the Health Act, 2017 entails a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

399. The definition is substantially reflected in the international instruments we have referred to. That being the position, any condition that in the opinion of a trained health professional, necessitates emergency treatment, or endangers the life or health of the mother, warrants an abortion. It is not the cause of the danger that determines whether an abortion is necessary but the effect of the danger. Therefore, if in the opinion of a trained health professional emergency treatment is necessary or the life or health of a mother is in danger, abortion is permissible. It therefore follows that if a pregnancy results from rape or defilement, and in the opinion of a trained health professional, endangers the physical, mental and social well-being of a mother, abortion is permissible (that is the health of the woman or girl).

400. In this case, it was in fact conceded by an expert called on behalf of the Respondents, Dr. Mutiso, that rape, subsequent pregnancy, abortion, infection, kidney failure, dialysis and surgery are indeed traumatic experiences regardless of where, when, how or why the person experiences them. He was however quick to add that not all traumatic experiences lead to post-traumatic stress disorder (PTSD). In other words, he did not rule out altogether the possibility of traumatic experiences resulting from rape, subsequent pregnancy, abortion, infection, kidney failure, dialysis and surgery leading to post-traumatic disorder.

401. The next issue is whether the DMS's impugned letter and Memo meet the test for limitation of rights set out in Article 24 of the Constitution. From our discourse above, the answer to this issue is clearly in the negative. It must therefore follow that the issue as to whether the decision to withdraw the 2012 Standards and Guidelines and Training Curriculum violated Articles 10 and 47 of the Constitution and the ***Fair Administrative Action Act***, must be answered in the affirmative. We also find that the withdrawal of the 2012 Standards and Guidelines, the Training Curriculum and Medabon was *ultra vires* the powers of the DMS since those powers are bestowed upon the Board.

402. It is also our finding that by withdrawing the 2012 Standards and Guidelines and the Training Curriculum, the DMS in effect disabled the efficacy of Article 26(4) of the Constitution and rendered it a dead letter. That action, which in our view constituted a limitation of the rights under Article 26(4), derogated from the core or essential content of the right. In our view, it was clearly not justifiable, was prejudicial to the petitioners, and violated the rights of the petitioners and other women and adolescent girls of reproductive age whose interest they represent to the highest attainable standard of health guaranteed under Article 43(1) (a). Since, this is a right that inures to women and girls only, the unjustifiable limitation amounted to the violation of their right to non-discrimination as well as the right to information, consumer rights, and right to benefit from scientific progress. We therefore find that the directive by the DMS created an environment in which survivors of sexual violence cannot access safe quality services despite the clear constitutional provisions.

403. Did the circumstances of JMM qualify her for post-abortal care under Article 43? A holistic reading of Article 43 of the Constitution with the Health Act leads us to the conclusion that JMM was clearly entitled to emergency treatment including post-abortal care. It is our view that all persons who are in need of treatment are entitled to health care and it matters not the circumstances under which they find themselves in those situations.

404. The next issue is whether PKM as the personal representative of the estate of JMM is entitled to comprehensive reparation, including indemnification for material and emotional harm suffered as a result of the actions of the respondents. From the evidence adduced before us it is clear that post-abortal care was wanting in the facilities, which ordinarily ought to have had such care, such as Kisii Level 5 Hospital. The post abortal care she received in the hospital was clearly wanting, it appears that there was no doctor in the hospital to attend to

her, and there were no dialysis services available. Apart from that, JMM was subjected to travel a long distance from Kisii Level 5 to Tenwek Hospital in a taxi due to her inability to afford ambulance services, services which in our view ought to have been afforded as part of emergency treatment services. There is no doubt in our mind that as a result of these deficiencies, PKM as the personal representative of the estate of JMM is entitled to comprehensive reparation including indemnification for material and emotional harm suffered as a result of the actions and omissions of the respondents.

405. As we have found the respondents violated the rights of the 2nd, 3rd and 4th Petitioners and the women and girls whom they represent by the withdrawal of the 2012 Standards and Guidelines and the Training Curriculum. Visram J (as he then was), when faced with such circumstances in **Orengo vs. Attorney-General & Another [2008] 1 EA 309** relied on **Rookes vs. Barnard [1964] A.C 1129; 1 ALL ER 367** and held that:

> ***"The behaviour of the defendants has clearly fallen into category of actions held by many courts in the past to be oppressive, arbitrary and unconstitutional and warrants an award of…damages…Damages are designed not only to compensate the plaintiff, but also to deter wrongful behaviour. The aim of exemplary damages is that it serves a valuable purpose in restraining the arbitrary and outrageous use of executive power. There are certain categories of cases in which an award of exemplary damages can serve a useful purpose in vindicating the strength of the law and thus affording practical justification for admitting into the civil law a principle, which ought logically to belong to the criminal. The first category of exemplary damages is oppressive, arbitrary or unconstitutional action by servants of the Government. Where one is more powerful than the another, it is inevitable that he will try to use his power to gain his ends; and if his power is much greater than the other's he might, perhaps, be said to be using it oppressively. If he uses his power illegally, he must, of course, pay for his illegality in the ordinary way; but he is not to be punished because he is more powerful. In the case of the Government it is different, for the servants of the Government are also the servants of the people and the use of their power must always be subordinate to their duty of service."***

406. We therefore point out that the purpose of public law is not only to civilize public power but also to assure the citizens that they live under a legal system which aims to protect their interests and preserve their rights. Therefore, when the court moulds the relief by granting 'compensation' in proceedings under Article 23 of the Constitution or seeking enforcement or protection of fundamental rights, it does so under the public law by way of penalizing the wrongdoer and fixing the liability for the public wrong on the state which has failed in its public duty to protect the fundamental rights of the citizen. The payment of compensation in such cases is not to be understood as it is generally understood in a civil action for damages under the private law but in the broader sense of providing relief by an order of making 'monetary amends' under the public law for the wrong done due to breach of public duty, by not protecting the fundamental rights of the citizen or by subjecting the citizen to acts which amount to infringement of the Constitution. (See **Kisilu Mutua v Attorney General [2017] eKLR).**

407. It is well settled that an award of compensation against the state is an appropriate and effective remedy for redress of an established infringement of a fundamental right under the Constitution. The quantum of compensation will, however, depend upon the facts and circumstances of each case. In principle, constitutional damages as a relief separate and distinct from remedies available under private law is competent. This is because a violation

of a constitutional right must of necessity find a remedy in one form or another, including a remedy in the form of compensation in monetary terms. (See **Kisilu Mutua v Attorney General Supra).**

408. Award of damages entails exercise of judicial discretion which should be exercised judicially. The discretion must be exercised upon reason and principle and not upon caprice or personal opinion. The jurisprudence that has emerged in cases of violation of fundamental rights has cleared the doubts about the nature and scope of this public law remedy evolved by the Court. The following principles clearly emerge from decided cases:

> ***i. Monetary compensation for violation of fundamental rights is now an acknowledged remedy in public law for enforcement and protection of fundamental rights;***
>
> ***ii. Such claim is distinct from, and in addition to a remedy in private law for damages for tort;***
>
> ***iii. This remedy would be available when it is the only practicable mode of redress available;***
>
> ***iv. Against a claim for compensation for violation of a fundamental right under the constitution, the defence of sovereign immunity would be inapplicable.***

(See V.K. Sircar, Compensation for Violation of Fundamental Rights, a new remedy in Public Law Distinct from relief of damages in tort, J.T.R.I. Journal – First Year, Issue – 2 - Year – April – June, 1995), available at http://ijtr.nic.in/articles/art7.pdf

409. Arriving at the award of damages is not an exact science. We are aware that no monetary sum can really erase the scarring of the soul and the suffering and deprivation of dignity and death that some of these violations of rights entail. When exercising this constitutional jurisdiction, the court is concerned to uphold, or vindicate, the constitutional right which has been contravened. A declaration by the court will articulate the fact of the violation, but in most cases, more will be required than words. If the person wronged has suffered pain, loss, death or damage, the court may award him/her compensation. The comparable common law measure of damages will often be a useful guide in assessing the amount of the compensation. But this measure is no more than a guide because the award of compensation is discretionary and, moreover, the violation of the constitutional right will not always be coterminous with the cause of action in law. (See **Attorney General v Ramanoop [2005] UKPC 15, [2006] 1 AC 338)**.

410. An award of compensation will go some distance towards vindicating the infringed constitutional right. How far it goes will depend on the circumstances, but in principle it may well not suffice. The fact that the right violated was a constitutional right adds an extra dimension to the wrong. An additional award, not necessarily of substantial size, may be needed to reflect the sense of public outrage, emphasise the importance of the constitutional rights and the gravity of the breach, and deter further breaches. All these elements have a place in helping the court arrive at a reasonable award. The court must consider and have regard to all the circumstances of the case.

411. The agony suffered by JMM and her mother and legal representative remind us that subjective feelings of incessant pain which culminated in death, upset, frustration worry, anxiety, mental distress, fear, grief, anguish, humiliation, unhappiness, stress, depression and so on and the degree of their intensity are incapable of objective proof or of measurement in

monetary terms. The assessment of compensation for an injury or loss, which is neither physical nor financial, presents special problems for the judicial process, which aims to produce results objectively justified by evidence, reason and precedent.

412. Differently stated, translating hurt feelings into hard currency is bound to be an artificial exercise. There is no medium of exchange or market for non-pecuniary losses and their monetary evaluation. It is a philosophical and policy exercise more than a legal or logical one. The award must be fair and reasonable, fairness being gauged by earlier decisions; but the award must also of necessity be arbitrary or conventional. No money can provide true restitution. (See **Andrews v Grand & Toy Alberta Ltd (1978) 83 DLR (3d) 452, 475-476)**.

413. In other words, although they are incapable of objective proof or measurement in monetary terms, hurt feelings are none the less real in human terms. The courts and tribunals have to do the best they can on the available material to make a sensible assessment, accepting that it is impossible to justify or explain a particular sum with the same kind of solid evidential foundation and persuasive practical reasoning available in the calculation of financial loss or compensation for bodily injury. **(See Edward Akong'o Oyugi & 2 others v Attorney General [2019] eKLR).**

414. Taking into account the need for deterrence of this sort of behaviour, especially by those in positions of power similar to the respondents, and due to lack of evidence and explanation provided by the respondents as to why JMM was subjected to the treatment she underwent at the hands of the agents of the respondents, we find that the events that took place subsequent to the date when JMM sought medical attention from the respondents' medical facilities, did not meet the standards expected from those medical facilities. Accordingly, the respondents are fully liable for damages suffered by JMM. Without breaking these down into different heads a and guided by the above principles and, the facts and circumstances of this case, we are of the view that a global award in the sum of Kshs. 3,000,000/= would be adequate compensation.

Disposition

415. For all the foregoing reasons, we make the following orders:

> ***1. A declaration be and is hereby issued that the right to the highest attainable standard of health, right to non-discrimination, right to information, consumer rights, and right to benefit from scientific progress of the 2nd, 3rd, and 4thPetitioners as women of reproductive age and other women and adolescent girls of reproductive age whose interest they represent have been violated and/or threatened by the 3rdRespondent's letter of 3rd December 2013, reference number MOH/CIR/2/1/2, and Memo dated 24th February 2014, reference number MOH/ADM/1/1/2;***
>
> ***2. A declaration be and is hereby issued that the 3rd Respondent's Memo dated 24th February 2014, reference number MOH/ADM/1/1/2 violated or threatened the rights of health care professionals to information, freedom of expression and association, consumer rights, and right to benefit from scientific progress;***
>
> ***3. An order be and is hereby issued decreeing that the 3rd Respondent's letter dated 3rd December 2013, reference number MOH/CIR/2/1/2, and the Memo dated 24th February 2014, reference number MOH/ADM/1/1/2, are unlawful, illegal, arbitrary, unconstitutional, and thus null and void ab initio, and are hereby quashed;***

4. A declaration be and is hereby issued declaring that abortion is illegal in Kenya save for the exceptions provided under Article 26(4) of the Constitution.

5. A declaration be and is hereby issued that pregnancy resulting from rape and defilement, if in the opinion of a trained health professional, poses a danger to the life or the health (physical, mental and social well-being) of the mother may be terminated under the exceptions provided under Article 26 (4) of the Constitution.

6. An order be and is hereby issued directing the Respondents jointly and or severally to pay PKM a sum of Ksh. 3,000,000/= being compensation for the physical, psychological, emotional and mental anguish, stress, pain, suffering and death of JMM occasioned by respondents violation of JMM's constitutional rights as herein above enumerated.

7. An order for all parties to bear their own costs of the suit, because the petition is brought in the public interest.

Dated, Delivered and Signed at Nairobi this 12th Day of June 2019

A O Muchelule M. Ngugi G V Odunga L A Achode J M Mativo

Judge Judge Judge Judge Judge