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Kenya's abortion law reform: A tale of hope and despair

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Abstract

In many contexts globally, abortion is a contentious and sensitive topic that revolves around many controversies with religious, moral and political dimensions. It equally is a public health concern, and striking a balance between these competing dialogues has often led to policy makers legislating to the detriment of women's autonomy. Pre- and post-independence, Kenya's abortion law reform can be aptly described as a tale of both hope and despair. The legislative landscape prior to 2010 resulted in the criminal prosecution of numerous women and medical providers labelled murderers. After the 2010 promulgation of a new Constitution, there was policy reprieve as article 26(4) expanded the grounds for access to abortion. This was followed by a wave of goodwill seen through the passage of a plethora of policies by the Ministry of Health that gave a sense of hope. Notably, though, the criminal prosecution of medical practitioners as well as women and girls has continued despite these favourable laws on paper. Coupled with a rising and aggressively vocal anti-gender movement that has firmly entrenched itself, it can be assumed that Kenya has a long way to go before women can enjoy the right to safe abortion guaranteed on paper.

1 Introduction and contextual analysis

The promulgation of the Constitution of Kenya, 2010 was a historic occasion for women and girls in Kenya. It strengthened the normative framework for the protection of human rights generally, and specifically for women and girls as it sought to address historical injustices and prejudicial treatment against women and girls. Several provisions are

significant, including articles 43(1)(a),[1] 27[2] and 26(4), which collectively seek to protect women's reproductive health and rights and protect women from discrimination based on pregnancy. While 2010 marked a historical occasion, the (living) history of Kenya remains fraught with contestations around access to abortion often to the detriment of women, girls and any persons capable of carrying a pregnancy as they continue to be prosecuted under the provisions of the Penal Code impacting the rates of unsafe abortion in Kenya.

Unsafe abortion remains one of the leading causes of maternal morbidity and mortality in Kenya. Almost 8 000 women die during pregnancy and childbirth in Kenya annually, representing 15 per cent of all the deaths of women aged 15 to 49 years.[3] Another 160 000 women are either injured or disabled because they are unable to access quality health care.[4] Within these discouraging numbers, unsafe abortion plays a prominent role. Unsafe abortion accounts for over 13 per cent of all cases of maternal mortality on Kenya.[5] A 2012 study by the Ministry of Health indicated that an estimated 464 000 induced abortions occur annually. About half of all the post-abortion care (PAC) clients were less than 25 years of age (48 per cent) with 17 per cent aged 10 to 19 years old.[6] A 2018 costing study on the financial implications of treating unsafe abortion in public health facilities additionally showed that most women with complications from unsafe abortion are treated in public health facilities, exerting pressure on scarce health system resources. The costs of this treatment were averaged to be Kenya Shillings 533 million.[7]

1 Art 43(1)(a) guarantees the right to the highest attainable standard of health including reproductive health.
2 Art 27 guarantees the right to equality and non-discrimination and includes sex and pregnancy as prohibited grounds for discrimination.
3 PriceWaterhouseCoopers 'Making a difference through health: How PwC is helping to change lives – Impact case studies', https://www.pwc.com/gx/en/healthcare/case-studies/making-a-difference-global-health-kenya-case-study.pdf (accessed 15 September 2021).
4 As above.
5 SF Mohammed and others 'The estimated incidence of induces abortion in Kenya: A cross-sectional study' (2015) 15 *BMC Pregnancy Childbirth* 185.
6 Ministry of Health & African Population and Health Research Centre (APHRC) 'Incidence and complications of unsafe abortion in Kenya', https://www.guttmacher.org/sites/default/files/report_pdf/abortion-in-kenya.pdf (accessed 15 September 2021).
7 Ministry of Health 'The costs of treating unsafe abortion complications in public health facilities in Kenya' (February 2018), https://aphrc.org/wp-content/

Additionally, empirical evidence demonstrates that 28 per cent of the complications arising as a result of unsafe abortion are of high severity, whereas 56 per cent were of low severity but still required treatment in a medical facility.[8]

The above confirms that women and girls will find a way to terminate a pregnancy even when there are no enabling legal and health systems and structures. The lived reality is that women and girls continue to procure unsafe abortions to the detriment of their health and well-being whether supported by the legal frameworks.

This chapter provides an analysis on the history of abortion in Kenya and attempts to answer the following question: Despite medical and legislative advancement in accessing a safe abortion, why does this remains illusory for many women in Kenya? We look at the pre- and post-colonial positions on abortion, the significant shift presented by the promulgation of the Constitution of Kenya, 2010, and the continued contestations over a decade after its promulgation, underscoring the impact of anti-sexual and reproductive health and rights actors. We conclude that despite legislative advancements, the promise of the Constitution of Kenya, 2010 falls short of having meaningful impact on the lives of women and girls who continue to resort to unsafe abortions, face criminalisation and are denied their reproductive rights.

2 Historical normative frameworks

2.1 Pre-colonial position

Giving a pre-colonial history of Africa is usually an uphill task, not because the history did not exist but because many written accounts are from missionaries, on the one hand, and men, on the other, who have a very specific lens when viewing not just the world but the peoples they were seeking to dominate.[9] There are, however, multiple accounts of abortion

uploads/2019/07/The-Costs-of-Treating-Unsafe-Abortion-Complications-in-Public-Health-Facilities-in-Kenya_Final.pdf (accessed 15 September 2021).

8 S Singh and others 'Abortion worldwide: A decade of uneven progress', https://www.guttmacher.org/report/abortion-worldwide-decade-uneven-progress (accessed 30 August 2021).

9 M Chisewe & C Macleod 'Cultural de-colonisation versus liberal approaches to abortion in Africa: The politics of representation and voice' (2018) 22 *Africa*

in pre-colonial African societies, including the Malagasy in Madagascar (abortion was used to control the number of children); the Maasai in Kenya; the Ovambo in Namibia; the Efik in Nigeria; and in Cameroon in instances where there were suspicions of foetal abnormality.[10]

Of course, it is a misnomer to speak of pre-colonial Kenya because Kenya did not exist before the colonial construct. However, some accounts of the colonial experience in Kenya provide insight into pre-colonial organisation. Among the Meru community (in the eastern part of Kenya), an account by a colonial report filed in 1910 states: 'If a girl happened to become pregnant before her initiation, a "miscarriage" would be brought about.'[11]

The documented history around this practice with the Meru ethnic community is tied to initiation – women who had not been initiated for marriage were considered children and as such unfit to carry a pregnancy or bear a child.[12] Children were a link to the ancestors, and those borne of unintended persons, it was believed, would be cursed.[13] This belief, reportedly, was also held among the Nandi, Maasai and Kipsigis of Kenya.[14]

The normative framework among these communities seemed less grounded around the control of women's autonomy explicitly, but more towards preserving procreation within a certain status because it was necessary to protect the child and to continue a lineage of humanity between the unborn, the living and the ancestors (living dead).

2.2 Colonial Kenya

For Britain and the British colonies, the initial major historical landmark in the development of an abortion law was the English Offences Against the Person Act, 1861 (1861 Act) which was transplanted, alongside its interpretation by the courts, to British colonies.[15] The main abortion

Journal of Reproductive Health 49.

10 Chisewe & Macleod (n 9) 53.

11 LM Thomas *Politics of the womb: Women, reproduction and the state in Kenya* (2003) 27.

12 Thomas (n 11) 27.

13 Thomas (n 11) 33.

14 As above.

15 RJ Cook & BM Dickens 'Abortion laws in African Commonwealth countries' (1981) 25 *Journal of African Law* 60.

provision – section 58 – made it an offence for a woman to 'unlawfully' procure an abortion. Section 59 of the Act punished a person who supplied the woman with the means for unlawfully procuring an abortion.

Section 58 of the English Offences Against the Person Act states:

> Every woman being with a child who, with intent to procure her miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with the intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of a felony and being convicted thereof shall be liable to imprisonment for life.

Significant jurisprudence in understanding the nuance between lawful and unlawful abortions was unpacked in the case of *R v Bourne*.[16] *Bourne* was decided in 1938, where the trial judge, McNaughten J, clarified the therapeutic exception in his direction to a jury. The case involved a doctor who had obtained parental consent to perform an abortion on a 14 year-old girl who had been raped. The doctor was charged with unlawfully procuring an abortion contrary to the 1861 Act. His defence was that the abortion was not unlawful and that he had intended to save the girl from greater harm that would follow from continuing with the pregnancy. The doctor claimed that he had provided the abortion so that the girl would not become a mother at such a tender age and give birth to a child conceived from rape. Experts testified that the minor child would be mentally devastated if she was required to continue with the pregnancy.

McNaughten J agreed and acquitted the doctor. In directing the jury, he stated:

> If the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequences of continuance with the pregnancy will be to make the woman a physical or mental wreck, the jury are entitled to take the view that the doctor who under those circumstances and in that honest belief operates, is operating for the purposes of saving the life of the mother.

The Penal Code, chapter 63 of the Laws of Kenya (Penal Code) was enacted in colonial Kenya and through sections 158-160 replicated the

16 [1938] 3 ALL ER 615, [1939] 1 KB 687.

English Offences of Person Act sections 58 and 59. The provisions of the Penal Code are similar to those of the 1861 Act with some slight nuances around the scope of criminal liability – while the English Act focused on women, the Penal Code applicable in Kenya was more expansive. The provisions state:

> 158 Attempts to procure abortion
> 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.
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> 159 The like by woman with child
> 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.
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> 160 Supplying drugs or instruments to procure abortion
> Any person who unlawfully supplies to or procures for any person any thing 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.

However, in light of the jurisprudence in *Bourne,* the following proviso was included in section 240 of Kenya's 1963 Penal Code, which provided reprieve for doctors not to be 'criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for her benefit or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case'.

Abortion-related offences are part of chapter XV of the Penal Code which legislates on offences against morality. The prohibitions in this chapter included rape, defilement, using premises for prostitution and unnatural offences (same sex-sex). What distinguishes these crimes from others in the Penal Code (offences against the person, relating to marriage), which arguably is underpinned in morality, is not their relation to morality but the absence of ordinary justification in a non-

theocratic state.[17] In a non-theocratic state penalising abortion, same sex-sex, sex work and similar crimes not grounded in an absence of consent or in a show of violence would be counter-intuitive. Thus, this framing allows for the imposition of inherently theocratic values without the naming of those values and creates the concept of a public morality which seemingly is static. In colonial Kenya the codification of the Penal Code created a shift in how abortion would be viewed in independent Kenya as an act so immoral that it was worthy of the state's intervention. Given this framing, the exceptions to criminal sanction were limited.

2.3 Independent Kenya (1963-2010)

While it would be tempting to attribute our position at independence solely to our inherited colonial legislative framework, that would not do justice to that discussion. A few notable issues are worth mentioning during this time period. First, religious leaders were highly organised and active in their resolve to counter any efforts relating to the provision of safe abortion services to women (this is seen throughout independence in 1963 to the constitutional negotiations in the 2000s).[18] Second, the existing legal framework that lends itself towards criminalisation of abortion within a context of non-nuanced understanding of formal legal systems and its interaction with societies. Finally, being a new nation grappling for a shared identity, the framing of womanhood was sometimes fixed to nurturer.[19]

This predicament followed the lack of laws on comprehensive sexual and reproductive health and the failure to implement progressive rules despite the existence of enabling international laws. In many ways, the challenges that women faced in the mid-twentieth century and early 1990s remain to date. This part reflects on how the development of abortion laws in independent Kenya demonstrates the disconnect

17 LB Schwartz 'Morals offences and the moral penal code' (1963) 63 *Columbia Law Review* 669-686.

18 Berkley Centre for Religion, Peace and World Affairs 'Faith and development in focus: Kenya' March 2017, https://jliflc.com/wp-content/uploads/2017/03/Faith-and-Development-in-Focus-Kenya.pdf (accessed 17 April 2024).

19 NA Were, LW Kroeger & TS Griffith 'Unmasking patriarchy: The family and traditional values discourse and the quest for reproductive health and rights of women' in C Kioko, R Kagumire & M Matandela (eds) *Challenging patriarchy: The role of patriarchy in the roll back of democracy* (2020) 24-27.

between legislation and the lived realities of women and the challenges that arise thereof.

2.3.1 International and regional law

Before 2010, Kenya operated as a dualist state. While this practice was not apparent from the Constitution of Kenya of 1969,[20] this was anchored in the Treaty Making and Ratification Act 45 of 2012 (later amended through the Treaty Making and Ratification (Amendment) Act).[21] In some instances, treaties were domesticated through enactment of a law, and in others, the courts would pronounce themselves and apply international law without domestication.[22]

Through the late 1990s, the need for progressive laws on women's rights was a global concern. It was heightened by the rise of grassroots women's empowerment organisations as seen through conferences such as the International Conference on Population and Development in Cairo, 1994 and the subsequent 1995 Beijing Conference.[23]

In Kenya, there were groups such as the *Maendeleo ya Wanawake* which advocated women's rights, bodily autonomy and inclusion.[24] Further, to complement the provisions of the Universal Declaration of Human Rights, two conventions on political, social and economic rights had been developed.[25] These are the International Covenant on Civil and Political

20 Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) 'Mapping the constitutional provisions on the right to health and the mechanisms for implementation' December 2018, https://www.equinetafrica.org/sites/default/files/uploads/documents/KELIN%20Kenya%20rights%20case%20study%202018.pdf (accessed 15 October 2021).

21 Secs 7 and 8 of the then Treaty Making and Ratification Act required Cabinet approval of the ratification of a treaty, and thereafter submission of the treaty and a memorandum to the Speaker of the National Assembly. The relevant parliamentary committee would during its consideration of the Treaty, ensure public participation in the ratification process in accordance with laid down parliamentary procedures, https://www.otienocarey.co.ke/admin/documents/Treaty%20Making%20and%20Ratification%20No%2045%20of%202012.pdf (accessed 5 January 2022).

22 KELIN (n 20) 7.

23 AS Walker 'The women's movement and its role in development' in JL Parpart, MP Connelly & VE Barriteau (eds) *Theoretical perspectives on gender and development* (2000). [page number]

24 N Kabira 'Constitutionalising travelling feminisms in Kenya' (2019) 52 *Cornell International Law Journal* 147.

25 Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200A (XXI) of 16 December 1966 for entry into force 3 January

Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[26] Kenya become a signatory ICESCR on 1 May 1972. Article 12 of ICESCR guarantees everyone the right to enjoy the highest attainable standards of physical and mental health. The United Nations (UN) ESCR Committee's General Comment 14 defines the right to health to include the right to reproductive health and individuals' ability to control their sexual and reproductive freedom.[27] Also relevant is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) to which Kenya is a party.[28] The CEDAW Committee's General Recommendation 24 advocates the amendment of legislation that criminalises abortion.[29] Further, General Recommendation 35 frames the criminalisation of abortion, a denial of or delay in access to safe abortion, forced pregnancy and forced continuation of pregnancy as forms of gender-based violence.[30]

Over the years, Kenya acceded to regional instruments including the African Charter on Human and Peoples' Rights (African Charter) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (African Women's Protocol).

The African human rights framework also offers an understanding into Kenya's obligations. The African Charter guarantees the right to the 'best attainable state of physical and mental health'.[31] The African Women's Protocol complements the African Charter and was developed with a view to providing comprehensive human rights protection for

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1976, in accordance with art 27.

26 While ICCPR does not explicitly mention reproductive health, provisions within it are necessary for the realisation of reproductive health and rights. For individuals to fully enjoy their sexual and reproductive health, they must have access to other social, political and economic rights, including the right to access information, the right to form associations, the right to freedom from torture and the right to life.

27 ESCR Committee General Comment 14: The right to the highest attainable standard of health (art 12 of the Covenant), 11 August 2000, UN Doc E/C.12/2000/4 (2000).

28 Kenya ratified CEDAW on 9 March 1984, https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=90&Lang=EN (accessed 5 January 2022).

29 CEDAW Committee General Recommendation 24: art 12 of the Convention (Women and Health), 1999, UN Doc A/54/38/Rev.1 ch I.

30 CEDAW Committee, General Recommendation 35 on gender-based violence against women, updating General Recommendation 19, 26 July 2017, UN Doc CEDAW/C/GC/35 (2017) para 18.

31 OAU African Charter on Human and Peoples' Rights (African Charter), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 ILM 58 (1982) art 16.

women. It contains provisions on women's rights on the political, social, and economic right fronts. Kenya ratified the Protocol (with reservations to the abortion provisions) in October 2010.[32] Article 14(2)(c) of the African Women's Protocol requires that states take adequate measures to protect the reproductive rights of women. It provides for abortion under specified circumstances: if the continued pregnancy endangers the life and physical or mental health of the pregnant woman or foetus; or in instances of sexual assault, incest or rape. Kenya's reservation was reported to be due to the conflict with domestic law stating that article 14(2)(c) was more expansive than article 26(4) of the Constitution, 2010.[33][34]

2.3.2 The Penal Code

In December 1963 the then President of Kenya, Jomo Kenyatta, called the citizens to *Harambee*. *Harambee* was a symbol of unity and a call to collectively realise the national agenda. As nurturers of society, women were at the heart of the *Harambee* agenda. They bore the generations that would form and build the new state. While seemingly benign, this identity that required women to build a nation through reproduction and nurturing has created a problematic and illusory dichotomy that has often placed the burden of reproduction solely on women.[35]

Therefore, intending to grow a nation, it was apparent that the restrictive pre-existing laws on abortion would persist. The significant misjoinder here, for the new nation, is represented by the fact that

32 African Union 'List of countries who have signed, ratified/acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa', https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf (accessed 5 November 2021).

33 Kenya National Commission on Human Rights 'Advisory on the Removal on Kenya's Reservation on Article 14 (2)(c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (September 2021), https://www.knchr.org/Portals/0/Final%20KNCHR%20Advisory%20on%20removal%20of%20reservation%20under%20Article%2014%20%282%29%20%28c%29%20of%20the%20Maputo%20Protocol.pdf (accessed 17 April 2024).

34 Equality Now 'The Maputo Protocol turns 18 today. But what does this mean for women and girls in Africa?' 11 July 2021, https://www.equalitynow.org/maputo_protocol_turns_18 (accessed 15 October 2021).

35 Were and others (n 19) 27.

colonial authorities condemned both female genital mutilation (or circumcision) and abortion, but only the criminalisation of abortion was maintained in independent Kenya,[36] cementing the need to control women's reproduction and limit their autonomy to engage in public life.

In addition, the deep cultural setting of Kenyan communities meant that children were still regarded as community 'property' and a woman could not exercise her bodily autonomy in any manner that would interfere with this understanding. In general, while the Constitution of Kenya, 1969 prohibited discrimination, the notions of affirmative action, gender equality and women's representation in governance were non-existent.[37] As such, women suffered the negative implications of exclusion by law, and they were additionally tied by traditions and religious norms. With this backdrop, the prohibitions on abortion were retained in sections 158, 159 and 160 of the Penal Code.

Borrowing from colonial laws continues to impact the applicability and consistency of abortion laws in Kenya. By 1995 (and around that period) almost 50 per cent of all gynaecological admissions involved incomplete abortion.[38] However, these statistics were not reflective of the legal position in Kenya, moving the Permanent Secretary for Health, in 1999, to remark on the misery caused by this colonial legacy.[39]

2.3.3 Court jurisprudence

During this era, 1963 to 2009, there are several significant cases that were decided by the courts expounding the provisions of the Penal Code. This part will not fully analyse the jurisprudence before 2010 because the magistrate's court is not a court of record and many of the decisions around sections 158 to 160 of the Penal Code are not reported. However, the decisions highlighted below give some insight into the interaction between abortion and murder in the context of Kenya and how some

36 Thomas (n 11) 23-27.

37 Constitution of Kenya, Act 5 of 1969, http://repository.kippra.or.ke/bitstream/handle/123456789/2324/THE%20CONSTITUTION%20OF%20KENYA%20ACT%201969%20No%205.%20of%201969.pdf?sequence=1&isAllowed=y (accessed 5 November 2021).

38 E Brookman-Amissah & J Banda Moyo 'Abortion law reform in sub-Saharan Africa: No turning back' (2004) 12 *Reproductive Health Matters* 227.

39 C Ngwena 'Access to abortion: Developments in Africa from a reproductive and sexual rights perspective' (2004) 19 *South Africa Public Law* 335-336.

of these theories then manifest into a broader narrative that abortion is murder.

One of the earliest cases, *Mehaar Singh Bansel v Republic*,[40] was an appeal against a conviction for manslaughter. The appellant, a surgeon, had terminated a pregnancy. The patient had died following the operation. Part of the prosecution's case was that the woman had died following an illegal abortion. At trial, the judge directed that an operation to terminate a pregnancy could only be lawful if it was done for the purpose of 'saving the patient's life or preventing severe prejudice to her health'. One of the grounds for appeal was that the trial judge misdirected the assessors on the relevance of abortion to the case. The Appeal Court, citing *Bourne*, held that there had been no misdirection and that the trial court had in fact 'carefully and correctly' directed the jury on what constitutes an illegal abortion. The Court upheld the conviction partly on the ground that the received law on abortion (that is, received through the Court's implicit approval of *Bourne*) had been carefully applied. This decision not only adopted the position in *Bourne*, but also made clear that the Penal Code criminalises illegal abortions, underscoring section 240, and the existence of legal abortions. The Court went further in this case to define an illegal abortion stating that 'one which is intended to terminate pregnancy for some reasons other than what can, perhaps be best be called a good medical reason, which the court interpreted to be the genuine belief that the operation is necessary for the purpose of saving the patients life or preventing severe prejudice to her health'.

Another significant case is *Republic v Nyamu*.[41] While this case was not centred on abortion or abortion-related offences, it is evidence of a conflation of both charges and offences in the prosecution of these offences. The three accused persons were charged with murder contrary to the Penal Code. The charge was framed as 'murder of an unidentified female person number 1912 weighing 3 012 grams and an unidentified male number 1913 weighing 2 232 grams'. Essentially, they were accused of murdering foetuses. A significant part of the matter turned on whether the 'unidentified female and male' were born alive and, relying on section

40 (1959) EALR 813 (East African Court of Appeal).
41 [2005] eKLR Criminal Case 81 of 2004.

214 of the Penal Code,[42] the Court held that 'for a child to become a person the most important ingredient is "when it has completely proceeded in a living state from the body of its mother". That ingredient is not present in this case. Without that the fetuses in two counts were not persons capable of being killed. There is no murder.'

The continued criminalisation of abortion and use of the Penal Code in court is equally witnessed in the criminal appeal of *Elnorah Kulola Ilongo v Republic*,[43] where the appellant was tried on a charge of procuring abortion contrary to section 159 of the Penal Code by trying to unlawfully administer to herself a poison called Aspirin and Fansidar. In quashing the conviction and setting aside the two-year prison sentence, the High Court Judge held that 'the appellant could have been saying the truth that she did not know that Fansidar, which is a common anti-malaria drug, could cause her miscarriage. No medical evidence was adduced. The appellant in my judgment ought to have been given benefit of doubt.'

On the contrary, the 2009 trial and conviction in *Republic v Jackson Tali* is illustrative of how stigma around abortion may cloud a judicial process.[44] The appellant was accused and convicted of murder in the trial court and sentenced to death. The prosecution's case was that the appellant had assisted the deceased in procuring an abortion which led to her death. This seven-page judgment is evident of how far a judge can go in over-explaining his own bias. In this regard, although the pathologist, Dr Johansen Odiwuor, in his evidence concluded that he was unable to establish the cause of death, the judge proceeds to outline exceptional cases where medical evidence is lacking but where there is direct and/or circumstantial evidence of what could have caused immediate death.[45] Moreover, despite the judge acknowledging that the evidence against the accused was partly direct and partly circumstantial, he fails to offer the benefit of the doubt and proceeds to sentence the nurse to death.

42 Sec 214 provides: 'A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has an independent circulation or not, and whether the navel-string is severed or not.'

43 eKLR Criminal Appeal 43 of 2007.

44 [2014] eKLR Criminal Case 75 of 2009; and [2017] eKLR Criminal Appeal 173 of 2016.

45 *Tali* (n 44) 6.

On appeal the Court noted several significant issues in the prosecution's case and overturned the conviction. The findings at appeal are telling of the possible bias in the trial process. First, the evidence from the pathologist indicated that the cause of death could not be established, that the foetus was still intact, and an abortion could not be proven. Second, the trial court relied on the hearsay evidence of a witness stating that the aunt of the deceased had confided in her and told her that the deceased had an abortion. This statement was not confirmed by the aunt who was not a witness. With these glaring gaps, the trial court had nonetheless sentenced the accused to death. The appeal court noted that the investigating officer, the prosecution and the judge at trial latched onto an abortion theory not supported by the evidence, stating that:

> in this case, there was no pretense by the prosecution that it was focusing on any one or more of the elements stated above to prove causation or intent. The theory of attempted abortion that was latched on by the investigating officer and eventually accepted and, with respect, unduly embellished by the trial court to found causation and intent, had its source in the witness Beatrice who heard it from Grace.

This case is telling of the possible stigma and bias held by different actors in the judicial process that impeded a fair trial and, ultimately, access to justice.

The jurisprudence above is not all the cases on abortion-related offences but some of the most significant cases that have shaped both how the courts regard abortion and the public narrative around abortion. Some key observations from the jurisprudence in this period is one of the major challenges faced around abortion-related offences, that it is a medical term or procedure that lacks a legal definition. *Mehaar Singh Bansel* somewhat closed the lacuna by providing a definition for an illegal abortion. However, as can be seen in the *Elnorah Kulola Ilongo* and *Jackson Tali* cases, there is very little understanding in law on what a legal abortion is, and the fact that one can take place outside of the parameters of the Penal Code. Another observation is the failure to distinguish between a spontaneous and an induced abortion. While the Penal Code refers to an induced abortion, it is often impossible to

clinically distinguish the two,[46] which results in unnecessarily subjecting women to criminal processes.

The third observation is the conflation between life and personhood and what rights accrue with personhood. While this question seemed settled by *Nyamu*, which notes that one must be born alive to be capable of being murdered, the conflation remains in Kenya, as will be seen further in this chapter.

Finally, there is the significant role stigma and bias around abortion play in the prosecution of and deciding on these cases. Failing to adduce or ignoring medical evidence, pursuing case theories single-mindedly are some of examples of how this has played out in the High Court, but are also illustrative of many experiences in the magistrate's court. The trial court and prosecution's conduct in some of these cases is so egregious that it paints a picture that the facts around the case are irrelevant if abortion is suspected.

2.4 Legislative reform post-2010

The promulgated 2010 Constitution of Kenya is hailed for its numerous progressive clauses advancing women's rights in many aspects. However, the final report of the Committee of Experts on Constitutional Review is telling of the contentious issues and resistance that the Committee experienced in reaching consensus with religious groups regarding article 26. Article 26 guarantees the right to life, stipulating that life begins at conception, and provides limitations on the right to life.[47] Article 26(4) of the Constitution expanded grounds under which a medical provider can now perform a safe abortion. These are; where there is danger to the life of the mother; where there is danger to the health of the mother;[48] if there is need for emergency treatment of any kind; and if allowed by any other written law.

46 VC Hamilton 'Clinical and laboratory differentiation of spontaneous and induced abortion: A study of 502 cases' (1941) *American Journal of Obstetrics and Gynecology* 61; A Moscrop '"Miscarriage or abortion?" Understanding the medical language of pregnancy loss in Britain: A historical perspective' (2013) *Med Humanit* 98.

47 Art 26 Constitution of Kenya, 2010.

48 Health, as defined in the Health Act, 2017 is a complete state of physical, mental and social well-being and not merely the absence of disease.

It is recorded that during the Committee's interactions with the clergy, the Committee discerned a rather unfortunate constant shifting of positions on two issues, access to abortion and the inclusion of Kadhi's courts in the document. At a meeting held on 15 July 2009, the Catholic Church was categorical that it had no objection to the inclusion of Kadhi's courts in the Constitution but insisted that abortion must be outlawed in the Constitution.[49]

Post-promulgation, critical changes in the grounds allowing for access to safe abortion and the bodies of trained healthcare providers offering safe abortion were expanded because of the promulgation of a new Constitution.

In an effort to recognise the challenges and shortages of specialised healthcare professionals in Kenya, the 2010 Constitution, for instance, moved beyond specialist doctors to involve a wider range of healthcare workers as an increasingly important public health strategy to address unsafe abortion.[50] In the final report of the Committee of Experts on Constitutional Review,[51] the drafters of the Constitution recognised that implementation of article 26(4) was not limited to doctors only but extended to nurses, clinical officers and midwives. Today, this position is now consolidated in the Health Act, 2017 which under section 6(2) clarifies that 'a trained health professional' who offers abortion 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 licence from the recognised regulatory authorities to carry out that procedure'.

Over the years, Parliament, County Assemblies as well as the Ministry of Health have made good on this last part to enact 'other forms of written laws' including the Health Act of 2017,[52] the Ministry of Health's National Guidelines on Management of Sexual Violence

49 Committee of Experts on Constitutional Review 'Final Report of the Committee of Experts on Constitutional Review' 11 October 2010, 10, https://katibaculturalrights.files.wordpress.com/2016/04/coe_final_report-2.pdf (accessed 5 January 2022).

50 T Saoyo *Legal framework on provision of safe abortion in Kenya* (2019).

51 Committee of Experts on Constitutional Review (n 49).

52 Health Act 27 of 2017, http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf (accessed 5 January 2022).

2014,[53] as well as various county laws to allow for circumstances under which safe termination of pregnancy is allowed.[54]

Beyond the expansion of grounds and the bodies of providers, it is also critical to note that the Constitution of 2010 allowed a singular provider to form an opinion on access to safe abortion. This law did not require the medical provider to seek a second opinion. Aware of the human resource limitations that exist in marginalised regions in Kenya, this is progressive as compared to the previous practice prior to 2010 where medical practitioners were compelled to seek the opinion of a senior healthcare practitioner or psychiatric review of the patient before allowing safe abortion.[55]

It is further noteworthy that pursuant to article 32 of the Constitution, freedom of religion, thought, opinion and belief remains a human right. While not outrightly stipulated, it can be inferred that the law allows for conscientious objection. Notably, though, article 43(2) of the Constitution qualifies this right by clarifying that no person shall be denied emergency medical treatment. This has been interpreted to mean that the right to invoke one's conscience is non-negotiable in emergency situations, including post-abortion care (PAC) which is classified as a lifesaving emergency medical treatment by the Ministry of Health's National Guidelines on Quality Obstetrics and Perinatal Care.[56]

53 Ministry of Health 'National Guidelines on Management of Sexual Violence' 3rd ed (2014), https://www.law.berkeley.edu/wp-content/uploads/2015/10/Kenya_Natl-Guidelines-on-Mgmt-of-Sexual-Violence_3rd-Edition_2014.pdf (accessed 5 January 2022).

54 Expounded further under 2.6, 'Devolution, counties, and abortion reform'.

55 Under the 2003 Code of Conduct and Discipline in Kenya, the attending practitioner was strongly advised to consult with at least two senior and experienced colleagues, obtain their opinion in writing and perform the operation openly in hospital if they consider themselves competent to do so in the absence of a gynaecologist. Republic of Kenya 'The Code of Professional Conduct and Discipline' 6th ed (Revised in January 2012), https://kmpdc.go.ke/resources/Code-of-Professional-Conduct-and-Discipline-6th-Edition.pdf (accessed 30 November 2021).

56 Ministry of Public Health and Sanitation & Ministry of Medical Services 'National Guidelines for Quality Obstetrics and Perinatal Care', http://guidelines.health.go.ke:8000/media/National_Guidelines_for_Quality_Obstetrics_and_Perinatal_Care.pdf (accessed 5 November 2021).

2.5 Beyond the Constitution: Abortion legal and policy reforms post-2010

After the enactment of the Constitution in 2010, at national level, the Ministry of Health has over the years adopted several policies, guidelines and operational frameworks that regulate and advance the provision of contraception, adolescent sexual health, access to safe abortion and PAC. Between 2012 and 2019, several policy documents were enacted in support of broadening and giving life to the provisions of article 26(4). These policies, laws and operational frameworks include, first, the Ministry of Health's National Guidelines For Quality Obstetrics And Perinatal Care.[57] Adopted in 2012, these Guidelines recognise abortion as a leading cause of maternal mortality. The Guidelines further recognise that among the six pillars of maternal and newborn health in Kenya is PAC. They define PAC as the care given to a woman who has had an unsafe, spontaneous or legally induced abortion. The Guidelines regulate PAC to include emergency treatment of complications from a spontaneous or unsafe induced abortion.

In the same year, in September 2012, the Ministry enacted abortion-specific Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya. Divided into four areas, the guiding principle of this document was to bring together all the aspects of care in preventing unsafe abortion using a multi-sectorial approach. The Guidelines were to be used by policy makers as well as frontline healthcare workers involved in the care of women seeking reproductive health services. It was to be used in making decisions for patient care.[58] Unfortunately, the document was as rapidly withdrawn as it had been enacted by the then director of medical services a year later, citing a lack of participation and wider consultations among stakeholders. This haphazard withdrawal of the Guidelines consequently led to a Constitutional Petition 266 of 2015*, Federation of Women Lawyers*

57 As above.

58 Ministry of Medical Services 'Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya' September 2012, https://www.safeabortionwomensright.org/wp-content/uploads/2018/02/Standards-Guidelines-for-the-Reduction-of-Morbidity-and-Mortality-from-Unsafe-Abortion.pdf (accessed 5 January 2022).

(FIDA-Kenya) v Attorney General challenging the withdrawal.[59] In a ground-breaking decision made by a five-judge bench in 2019, the High Court found that the director of medical services and the Ministry of Health had violated the rights of Kenyan women by arbitrarily withdrawing the Guidelines.[60] This judgment has since been challenged by radical fundamentalist group, Kenya Christian Professionals Forum, and is currently on appeal.

In 2014 the Ministry revised the 2009 National Guidelines on the Management of Sexual Violence.[61] The Guidelines allow for survivors of rape or defilement to have access to safe termination of pregnancy in line with the Sexual Offences Act.[62] They require healthcare providers to test every survivor for pregnancy and HIV, and where results are negative for both tests, administer emergency contraception and post-exposure prophylaxis to prevent unintended pregnancies and HIV.

The National Adolescent and Youth Friendly Services Guidelines, 2016[63] recognise that the essential package for adolescent and youth-friendly service provision includes 20 minimum provisions on areas such as counselling on sexual reproductive health; information and education; pregnancy testing; contraception counselling and provision of full range of contraceptive methods, including long-acting reversible methods, PAC and sexual and gender-based violence (SGBV) counselling services; and referrals to additional multi-sectoral response services.

Similarly, the 2018 edition of the National Family Planning Guidelines for Service Providers recognise that family planning

59 [2019] eKLR Petition 266 of 2015; Centre for Reproductive Rights 'Kenya's High Court issues a landmark ruling on access to safe abortion in a case against Ministry of Health' 6 December 2019, https://reproductiverights.org/kenyas-high-court-issues-a-landmark-ruling-on-access-to-safe-abortion-in-a-case-against-ministry-of-health%E2%80%AF/ (accessed 5 January 2022).

60 Judgment available on http://kenyalaw.org/caselaw/cases/view/175490/ (accessed 5 January 2022). See also African Commission 'Press release on the decision of the High Court of Kenya regarding the 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' 20 June 2019, https://www.achpr.org/pressrelease/detail?id=417 (accessed 5 January 2022).

61 Ministry of Health (n 53).

62 Ministry of Health (n 53).

63 Ministry of Health 'National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya' 2nd ed (2016), https://faces.ucsf.edu/sites/g/files/tkssra4711/f/YouthGuidelines2016.pdf (accessed 5 November 2021).

information and services are a component of the PAC package.[64] After an abortion, fertility resumes almost immediately (within two weeks) and, hence, non-coercive counselling and administration of contraception are recommended. In addition to the above, the Ministry's Post-Abortion Care Guidelines: A pocket guide for healthcare providers, 2019 are complementary to the post-abortion manual and curriculum developed by the Ministry of Health and are intended to guide healthcare workers on the management of incomplete abortion complications, counselling, and administration of post-abortion family planning, among others. The Guidelines recognise PAC as an emergency medical treatment protected under article 43(2) of the Constitution.[65]

It is equally important to note that besides policy reforms at the Ministry of Health, the Code of Professional Conduct and Discipline for Doctors, (MPDB 2012), the Code of Professional Conduct for Clinical Officers (2012); Standards of Nursing Education and Practice; and Code of Ethics and Conduct and Scope of Practice for Nurses in Kenya were all revised after the enactment of the 2010 Constitution to recognise the healthcare provider's role in the provision of access to safe abortions, timely and effective referral as well as the documentation of such cases.

Additionally, in 2017, Parliament enacted the Health Act 2017. Section 6(1) of the Act is instructive on abortion matters as it provides:

> Every person has a right to reproductive healthcare which includes:
>
> ...
>
> (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.

Section 6(2) thereafter defines 'a trained health professional' to refer to a healthcare professional with formal medical training at the proficiency level of a medical officer, a nurse, midwife, or a clinical officer who has

64 Ministry of Health 'National Family Planning Guidelines for Service Providers' 6th ed (2018), https://tciurbanhealth.org/wp-content/uploads/2019/04/Kenya-National-Family-Planning-Guidelines-6th-Edition-for-Print.pdf (accessed 5 November 2021).

65 Ministry's 'Post-abortion care guidelines: A pocket guide for health care providers' (2019), https://globaldoctorsforchoice.org/wp-content/uploads/MOH-PAC-GUIDELINES-Feb-2019.pdf (accessed 31 January 2022).

been educated and trained to proficiency in the skills needed to manage pregnancy-related complications in women, and who has a valid licence from the recognised regulatory authorities to carry out that procedure reaffirming the expansion of access to care through increasing qualified personnel that can provide it as discussed above.

2.6 Devolution, counties and abortion reform

In the wake of the 2013 transition to devolved governments, one of the main pillars of the new constitutional dispensation became decentralisation of public decision-making processes. Under the Fourth Schedule to the 2010 Constitution, health is categorised as a shared function between the national and county governments. The national government is mandated to supervise national referral health facilities as well as enact health policies; while the implementation of services, such as promotion of primary health care, supervision of ambulance services, veterinary services, among others, fall under the county government. The assignment of functions was further elaborated in the Legislative Supplement, Legal Notices 137-183 of 2013 whereby certain functions were transferred to county governments, including the promotion of primary health care including health education, health promotion, community health services, reproductive health and child health, among others.

As a result, county governments have begun enacting health-related laws and policies with the aim of governing the provision of primary health services, including reproductive health services, within their borders. County governments such as Makueni, Kilifi, Kakamega and Mombasa have to date all enacted various forms of maternal, newborn, child health and reproductive health acts with many of these legislative instruments influenced heavily by the county specific culture, data driven needs as well as priority setting.

Enacted in 2017, Makueni county became the first to legislate on maternal, newborn and child health.[66] This particular Act has been deemed extremely progressive on many fronts including access to

66 Makueni County Maternal, Newborn and Child Health Act, 2017, http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2017/MakueniCountyMaternalNewbornandChildHealthBill2017.pdf (accessed 5 November 2021).

safe abortion, access to contraception for adolescents, conscientious objection and PAC. Makueni's Maternal Newborn and Child Health (MNCH) Act, 2017 recognises termination of pregnancy under section 6 under a wide array of circumstances including rape or defilement, fetal abnormality, as well as mental incapacity to appreciate the pregnancy.

Section 7 of the Makueni MNCH Act further recognises that the statement of a woman who has been sexually assaulted is sufficient proof of the allegation. This is a progressive step towards reducing the requirements that women must meet before accessing urgent services as intimated by the courts in both Kenya and Zimbabwe.[67] In the case of a pregnant minor, the Makueni County MNCH Act requires the healthcare service provider to advise the minor to consult with her parents, guardian or such other persons with parental responsibility over the said minor before the pregnancy is terminated, provided that the best interests of the minor shall prevail.

Equally noteworthy is the provision on PAC in Makueni's MNCH Act, which includes (a) treatment of incomplete and unsafe abortion and complications that are potentially life-threatening; (b) post-abortion counselling to assess the woman's emotional and health needs; (c) post-abortion family planning, counselling, and contraception services; (d) referral to reproductive and other health services; and (e) community linkages for appropriate support.

Mombasa and Kilifi counties have equally passed reproductive health laws regulating abortion. Section 22 of Mombasa's Reproductive Health Act states: 'A pregnancy may be terminated if a trained health professional, after consultation with the pregnant woman, is of the opinion that (a) the continued pregnancy would endanger the health of

67 *Mildred Mapingure v Minister of Home Affairs* (2014) SC 22/14, Civil Appeal SC 406/12 Zimbabwe, Supreme Court. On 4 April 2006, Mildred Mapingure, the appellant in the case, was attacked and raped by robbers at her home. She immediately reported the matter to police and requested that she be taken to a medical practitioner to be given medication to prevent pregnancy (emergency contraception) and any sexually-transmitted infection. The doctor insisted that he could only attend to her in the presence of a police officer. The Court held that the police failed in their duty to assist the appellant in accessing timely services to prevent pregnancy. The doctor (second respondent) also failed to carry out his professional duty to avert the pregnancy when it could have been reasonably prevented. These unlawful omissions took place within the course and scope of their employment and, therefore, the first and second respondents were vicariously liable to compensate the appellant for the harm resulting from the failure to enable her to prevent pregnancy.

the mother; or (b) as a result of the pregnancy the life or health of the mother is in danger.'

It is worth noting that Kakamega's Maternal Child Health and Family Planning Act, 2017 makes no mention of abortion.

2.7 Judicial precedence post-2010 and prosecution of women

In the wake of a new Constitution, Kenya's judiciary has had a chance to unpack article 26(4) of the Constitution and interrogate abortion in *Federation of Women Lawyers (FIDA-Kenya) v Attorney General*.[68] Whereas this case currently is on appeal, the High Court reaffirmed the position taken years ago in *Bourne* and categorically declared 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'.

The above decision provides an expansive interpretation of article 26(4) of the Constitution of Kenya, 2010 by including the Sexual Offences Act, 2006 as any other law as stipulated in the article. This inclusion supports an argument to lift Kenya's reservation on the African Women's Protocol as it cannot be said to conflict with domestic law, and it further codifies the expansion of the grounds under which one can access an abortion in Kenya to include threat to life and health, emergency treatment, and if the pregnancy resulted from sexual violence. Another positive decision is *PAK & Another v the Attorney General and 3 Others*[69] in which the Court declared that abortion is a fundamental right, but it cannot be said to be an absolute right. This case is, however, presently on appeal, the eventual outcome of which is unknown. While a positive judgment the underlying facts is illustrative of the continued prosecution of women and girls under the Penal Code, in this case a 15 year-old girl that was experiencing a spontaneous abortion was criminally prosecuted for seeking healthcare services.

68 There currently are two cases before the High Court which, if determined, may give further pronouncements on the role of the Ministry of Health in safeguarding post-abortion care as emergency treatment (*Network of Adolescents and Youth in Africa v Ministry of Health* Petition 428 of 2018) and the rights of an unborn foetus to damages (*Ann Kioko v Medical Practitioners and Dentist Council* Petition E008 of 2020).

69 Constitutional Petition E009 of 2020) [2022] KEHC 262 (KLR).

Following the above legislative and policy reforms, one would be tempted to think that the current environment is conducive to access to safe abortion in Kenya. Notably, though, the lower magistrate's courts have continued witnessing prosecution of criminal offences against medical practitioners and women post-2010. This is as seen in the prosecution of KN in the senior principal magistrate's court in Kilifi under case 513 of 2013, where a clinical officer was charged with unlawfully administering Misoprostol to aide a patient to procure an abortion.[70] The accused was acquitted under section 215 of the Criminal Procedure Code in 2019. In *R v EM*,[71] at the Kigumo law courts, the accused person, a nurse, was charged on 1 December 2015 with the offence of attempting to procure an abortion, contrary to section 158. The case was later abandoned by the prosecutor and the nurse was acquitted under section 202 of the Criminal Procedure code for want of prosecution.[72]

In *Republic v DK & BO*[73] a member of the police force posed as a 'patient' seeking an abortion resulting in a nurse and receptionist being charged with contravening section 158 of the Penal Code. This case was dismissed after multiple adjournments. Another illustration of entrapment is *Republic v ENM*[74] where police stormed the clinic in the middle of a consultation and arrested the medial practitioner. The case was later withdrawn. In *Republic v JKN*[75] the patient, accompanied by her mother and uncle, sought to consult the accused, a medical practitioner. This consultation was interrupted by police accusing them of seeking to procure an abortion, resulting in the arrest of the patient and the medical provider and the subsequent charging of the medial provider. *Republic v KCM*[76] is related to the previous case; the patient was a 15 year-old girl who was charged with procuring an abortion contrary to section 159 of the Penal Code. She plead guilty to the offence and her mother was separately charged with aiding and abetting her.

70 Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) 'Research documenting the practice of prosecution of women and medical providers post enactment of article 26(4) on access to abortions since 2010' (2018) 69.
71 Criminal Case 2020 of 2015.
72 KELIN (n 70).
73 Criminal Case 4469 of 2013.
74 Criminal Case 2020 of 2015.
75 Criminal Case 536 of 2013.
76 Criminal Case 463 of 2016.

The consistent theme in many of these cases is that the police have already identified medical providers that they target and harass in relation to abortion. This and other behaviour by the police and communities can be credited with driving women to other sources for abortions that are unsafe.

2.8. Gaps between policy and the lived realities of women in Kenya

The part above on jurisprudence teaches that despite significantly changing a framework to support access to abortion within the parameters of the law, the reality for women and girls has not been illustrative of the constitutional promise. The statistics around maternal mortality resulting from unsafe abortion have remained. In the 2012 study it was estimated that 266 Kenyan women died per 100 000 unsafe abortions and about 157 762 received care for induced and spontaneous abortions every year.[77] Women seeking abortion-related care (including those who had resorted to unsafe abortions) were demographically heterogenous, including married and unmarried, educated and uneducated, of varying faiths, employed, self-employed and unemployed.[78]

Some of the reasons propounded for the incidences of unsafe abortion are the following: Despite making considerable progress in this area in the last two decades, the unmet needs for access to contraceptives stands at 14 per cent for married women and 19 per cent for sexually active unmarried women;[79] a lack of comprehensive sexuality education and reproductive health information in and out of schools;[80] a lack of knowledge and information on where safe abortion services can be accessed;[81] the punitive laws around abortion compounded with a

77 Ministry of Health (n 7) 7.
78 As above.
79 Kenya National Bureau of Statistics 'Kenya Demographic and Health Survey 2022: Key Indicators Report', https://dhsprogram.com/pubs/pdf/PR143/PR143.pdf (accessed 17 April 2024).
80 CO Izugbara, C Egesa & R Okelo '"High profile health facilities can add to your trouble": Women, stigma, and un/safe abortion in Kenya' (2015) 141 *Social Science and Medicine* 9-18.
81 Kenya Medical Association 'Chief conspirators in unsafe abortion and maternal deaths in Kenya: The role of existing laws and policies, health systems and duty bearers', https://kma.co.ke/images/CHIEF_CONSPIRATORS_IN_UNSAFE_ABORTION_AND_MATERNAL_DEATHS_IN_KENYA.pdf (accessed 17 April 2024).

lack of knowledge on enabling provisions;[82] prohibitive financial costs with most safe abortions being availed in the private sector and outside of public health facilities;[83] and stigma in communities and among healthcare providers around abortion.[84]

Women and girls who should have access to lawful abortions often find themselves seeking unlawful abortions (that is, those not provided within the prescripts of the myriad of laws and policies) because of the reasons above, either individually or cumulatively. This was documented in *Federation of Women Lawyers (FIDA-Kenya) v Attorney General* – the story of JMM, an 18 year-old girl who died after developing chronic kidney disease because of a septic abortion. She fell pregnant at the age of 14 years after having been defiled by an older man, and due to failures within the public healthcare system, she resorted to an unsafe abortion which caused her death at only 18.[85]

JMM's story is not unique and illustrative of the situation for other women and girls in similar situations.[86] Studies seeking the perspectives of women have recorded similar experiences with women sometimes opting for low-quality services because they offered greater confidentiality, and protecting their reputations as well as maintaining social integrity is an important factor to consider with stigma around abortion in Kenya.[87] Second, healthcare providers have been found to be judgmental and to show condemnation to women seeking abortion services, impacting their willingness to use qualified facilities.[88] Finally, despite legislative and policy advances, many women still believe that abortion is illegal (without exceptions) and their sources for information have included religious leaders, the Kenyan media, schools, and so forth, and this then results in women focusing on seeking abortions in places that can shield them from criminal prosecution.[89]

82 As above.
83 As above.
84 As above.
85 Petition 266 of 2015; judgment at paras 1-11.
86 C Izugbara & C Egesa 'The management of unwanted pregnancy among women in Nairobi Kenya' (2014) 26 *International Journal of Sexual Health* 100-112.
87 Izugbara and others (n 76).
88 As above.
89 RT Jayaweera and others 'Women's experiences with unplanned pregnancy and abortion in Kenya: A qualitative study' (2018) 13 *PLoS One*; Izugbara and others (n 76).

While Kenya has made significant progress in liberalising laws on abortion since 2010, this has not significantly impacted the experiences of women and girls who continue to be governed by mostly punitive laws due to the continued stigma around abortion, which over-emphasises criminalisation. While the Constitution, 2010 was significant in articulating the right to an abortion, it did so on reluctant terms and that reluctance has played out since its promulgation, causing an ever-growing tension to the detriment of the lives and health of women and girls.

2.9. Role of civil society

In many instances, civil society organisations continue to play a significant role in providing *pro bono* legal advice and representation of both medical officers and women charged with abortion-related offences. Groups such as Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), Federation of Women Lawyers-Kenya, Reproductive Health Network, Trust for Indigenous Culture and Health, Women's Link Worldwide and the Centre for Reproductive Rights continue to advance the right to safe abortion through the setting up of hotlines that offer accurate information on access to safe services, or through the provision of *pro bono* legal services to those arrested or by invoking public interest litigation and challenging the government when it issues directives contrary to the Constitution. These same groups were instrumental in vocalising, protesting and suing the government, thus enabling the lifting of a ban that had been issued in November 2018 shutting down Marie Stopes Kenya by the Kenya Medical Practitioners' and Dentists Council (Medical Council).[90]

Much of the work done in documenting the lived experiences of women and girls was made possible by a documentation of the prosecutorial trends and practices within the magistrate's courts that was completed by KELIN. The magistrate's court is not a court of record

90 'Kenya bans Marie Stopes from offering abortion services' *BBC Africa* 18 November 2018, https://www.bbc.com/news/world-africa-46254630 (accessed 5 November 2021). See also N Ballah 'Campaigners in Kenya challenge Marie Stopes abortion ban in court' *Reuters* 30 November 2018, https://www.reuters.com/article/us-kenya-abortion-idUSKCN1NZ22W (accessed 5 November 2021).

in Kenya and accessing decisions is an expensive and time-consuming endeavour. This documentation, while yet to be published, surfaced knowledge that would otherwise be difficult to access, and provided insight into prosecutorial practices in targeting women, girls and medical service providers, including the utilisation of sections of the Penal Code on the concealment of birth and infanticide, to target women suspected of having procured an abortion.[91]

3 The emergence and rise of anti-SRHR groups

The past four years have witnessed an increasingly troubling trend. Widespread anti-sexual and reproductive health and rights (SRHR) 'opposition' groups have gradually managed to infiltrate Kenya's parliaments, courts and the executive, with an agenda aimed at influencing legal policies, court decisions and other government directives in the health and education sectors.[92] More recently, in 2018, this trend was visibly demonstrated by the decision of duty bearers, including the Ministry of Health and the Medical Council, to suspend critical healthcare services on access to safe abortion.[93]

In November 2018 the Medical Council suspended the services of Marie Stopes Kenya following a complaint.[94] The complaint had been instigated by an online petition crafted by CitizenGO, an organisation duly registered in Spain, demanding for Marie Stopes Kenya to be shut down.[95]

91 Secs 227 and 210 of the Penal Code respectively.

92 In December 2013, these groups managed to influence the withdrawal by the Ministry of Health of the Kenyan Standards and Guidelines on prevention of maternal morbidity and mortality from unsafe abortion. The opposition movement has also increasingly hosted meetings, including the Africa Regional World Congress of Families which was hosted in May 2018 in Kenya, inviting the participation of Kenya's first lady and judiciary (family division) in a debate that saw the attempt to introduce a 'National Family Promotion and Protection' policy through the Ministry of Labour and Social Protection.

93 CitizenGO Africa 'Ask Sweden to stop funding abortion and homosexuality in Africa' 13 May 2020, https://www.citizengo.org/en-af/fm/179415-ask-sweden-stop-funding-abortion-and-homosexuality-africa (accessed 5 November 2021).

94 *BBC Africa* (n 86).

95 CitizenGO Africa 'Stop Marie Stopes abortion activities in Nigeria' (2 May 2019), https://www.citizengo.org/en-af/lf/170400-stop-marie-stopes-abortion-activities-nigeria (accessed 5 November 2021).

For the longest time, the anti-choice movement was publicly seen to be led by international, America-based actors such as Family Watch International, Human Life International and the World Congress of Families. These faces, however, have morphed with more 'local' actors across the globe. Beyond the new actors, this adaptive movement's strategies and tactics have also evolved in response to changes in the political and social landscape. While religious fundamentalism, patriarchy and authoritarianism remain at the core, the organised opposition has reframed the movement with new global actors such as Red Familia from Mexico, Agenda Europe and CitizenGO from Spain claiming the space.[96] In Kenya, organisations such as Kenya Conference of Catholic Bishops, Empowered Youth Coalition, East Africa Centre for Law and Justice, Sozo Church of God and Kenya Christian Professionals Forum have emerged as vocally spearheading projects against safe abortion. At the national setting, these groups are registered as local non-governmental organisations (NGOs) and occupy professional spaces as medical practitioners, lawyers, policy analysts, media experts, government officials and law makers. What remains constant is the morality attacks and messaging against access to safe abortion, the rejection of comprehensive sexuality education in schools and mis-informed messaging around sexual orientation and gender identity.

A significant shift has been in the language of anti-SRHR groups who have co-opted and weaponised human rights language and have been utilising tools such as strategic litigation to impact women's access to abortion. In several ongoing cases before the High Court of Kenya, the issues have been framed as contestations between a woman's right to choose and to autonomy of her body versus the rights of the 'unborn child'. This contestation has been made possible, first, by the framing in the Constitution which states that life begins at conception, and the long-standing conflation between life and personhood in Kenya. In *Network of Adolescents and Youth in Africa v Ministry of Health* and *Ann Kioko v Medical Practitioners and Dentist Council* the rights of the 'unborn child', though previously unarticulated, have been relied upon to lay a claim for

96 T Wilson 'Mapping the funding of the global anti-gender ideology movement' Global Philanthropy Project April 2020, https://globalphilanthropyproject.org/wp-content/uploads/2020/11/MTM-Summary-.pdf (accessed 5 January 2022).

damages and seek remedies to halt the provision of abortion services in healthcare facilities.

As a result, deliberate efforts to undermine sexual and reproductive rights that generate fear and misinformation, as well as claw-back on progressive policies, have been witnessed in Kenya with the failed Reproductive Health Bill of 2020, the current attacks on the East Africa Community Sexual and Reproductive Bill,[97] as well as Kenya's signature of the Geneva Consensus Declaration, a non-binding but problematic agreement that insists that abortion is not a human right.[98]

4 Conclusion

Despite the enactment of progressive policies and legislative frameworks post-2010, Kenya's healthcare providers remain reluctant to offer safe abortion services to women who qualify under article 26(4) for fear of incarceration and due to constant harassment and blackmail. Women continue to be prosecuted under the provisions of sections 158 and 159 of the Penal Code, driving what would have been a legally qualifying case to unqualified persons. While advancements have been made on paper, the concept of safe abortion remains highly emotive, stigmatised and unacceptable, particularly in religious forums that continue propagating the narrative that abortion is murder. This demonisation and harassment have been further fuelled by a new crop of local anti-SRHR actors that seem determined to 'sanitise' society with doctrines of life, morality, family and Christ. Consequently, this has driven a handful of civil society organisations towards the adoption of legal and advocacy strategies in and outside court to advance the provisions of the Constitution, challenge the government and consistently offer legal reassurance to those wrongfully prosecuted for exercising their rights to safe services. An interrogation of Kenya's pre- and post-colonial regulations on abortion seem to reflect a society that struggles to accept that it has paper tigers

97 CitizenGo Africa 'Stop the Abortion and Sexualization Bill at the East African Legislative Assembly' 28 April 2021, https://citizengo.org/en-af/lf/202030-stop-abortion-and-sexualization-bill-east-african-legislative-assembly (accessed 5 November 2021).

98 Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, https://usun.usmission.gov/geneva-consensus-declaration-on-promoting-womens-health-and-strengthening-the-family/ (accessed 5 November 2021).

confidently protecting women in law but, in practice, continuing long-held beliefs of subjugation, bodily control and patriarchy. Between 2007, when Elnorah Kulola Ilongo was prosecuted under the Penal Code, and now, nothing in practice has shifted.

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