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REPUBLIC OF KENYA
IN THE HIGH COURT OF KENYA AT NAIROBI
CONSTITUTIONAL AND HUMAN RIGHTS DIVISION

PETITION NO. 606 OF 2014

IN THE MATTER OF THE ENFORCEMENT OF THE BILL OF RIGHTS UNDER ARTICLE 22(1) OF THE CONSTITUTION OF KENYA (2010)

AND

IN THE MATTER OF THE ALLEGED CONTRAVENTION OF ARTICLES 19,20,21,25,27,28,29,31,33,35,43,45 AND 46 OF THE CONSTITUTION OF KENYA (2010)

BETWEEN

L.A.W.....1ST PETITIONER

KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV & AIDS (KELIN) .....2ND PETITIONER

PATRICK 2-35

AFRICAN GENDER AND MEDIA INITIATIVE TRUST (GEM) .....3RD PETITIONER

AND

MARURA MATERNITY & NURSING HOME.....1ST RESPONDENT

COUNTY EXECUTIVE COMMITTEE MEMBER IN CHARGE OF HEALTH SERVICES – NAIROBI COUNTY.....2ND RESPONDENT

CABINET SECRETARY, MINISTRY OF HEALTH.....3RD RESPONDENT
THE HON. ATTORNEY GENERAL.....4TH RESPONDENT

AND

THE SECRETARIAT OF THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS Secretariat) .....1ST AMICUS CURIAE

PROFESSOR ALICIA ELY YAMIN .....2ND AMICUS CURIAE

NATIONAL GENDER AND EQUALITY COMMISSION (NGEC) .....3RD AMICUS CURIAE

THE INTERNATIONAL COMMUNITY OF WOMEN

LIVING WITH HIV(ICW).....INTERESTED PARTY

Pursuant to Article 22 (1) of the Constitution of Kenya (2010) and The Constitution of Kenya (Protection of rights and fundamental freedoms) Practice and Procedure Rules, 2013.

2nd AMICUS WRITTEN SUBMISSIONS

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I. BACKGROUND OF THE CASE

1. While she was pregnant in March 2006, the 1st Petitioner tested positive for HIV at Kariobangi Health Center. The results were later confirmed at Baba Dogo Health Center. During her follow-up visits to the center, the 1st Petitioner was advised by a nurse that, due to her HIV status, she should not have any more children. Baba Dogo Health Center later sent her to see a Community Health Worker who gave her two vouchers to use for her delivery at Marura Maternity and Nursing Home. The vouchers were marked "CS" and "TL."

2. On September 15, 2006, the 1st petitioner went into labor and was admitted to Marura Maternity and Nursing Home, where she was prepared for a cesarean section. Before beginning the operation, the doctor asked her name, age, and for the number of children she had.

3. Following the successful operation and birth, the 1st Petitioner and her husband found that they were unable to conceive another child. In July 2010, she visited a medical camp in Mathare, where a doctor performed various tests to determine the cause of her infertility. The doctor then informed her that she was unable to conceive because she had undergone a tubal ligation.

4. The 1st Petitioner claims that the tubal ligation was performed without her informed consent and constitutes a violation of her human rights.

5. The 1st respondent has denied the allegations and insist that consent was duly obtained. The 3rd and 4th respondents have also denied liability or any involvement in the violations alleged by the 1st petitioner.

II. EXPERTISE OF THE AMICUS CURIAE

6. On January 28, 2016, Professor Alicia Ely Yamin was admitted as *amicus curiae* in these proceedings. Under the order of this Honourable Court, she is permitted to make written submissions.

7. The expertise of the *amicus curiae* was outlined in the application to intervene but is briefly restated here.

8. Professor Yamin is one of the foremost experts on matters of health in international human rights law, including with respect to sexual and reproductive health, and has been a pioneering thought leader in the field of social and economic rights, and the right to health in international law and comparative constitutional law.

9. Professor Yamin holds faculty positions at the Harvard Law School in Cambridge, Massachusetts, the Harvard T.H. Chan School of Public Health in Boston, Massachusetts, as well as the Centre on Law and Social Transformation of the University of Bergen in Norway. Additionally, Professor Yamin is the Policy Director of Harvard University's FXB Center, which was founded in 1993 through a gift from the Association François-Xavier Bagnoud and is the first academic center to focus exclusively on the intersection of health and human rights. The FXB Center has the objective of advancing this field by combining research and teaching with a strong commitment to service and policy development, which, as Policy Director, Professor Yamin leads.

10. Professor Yamin has experience advising courts and other government entities, as well as international bodies and UN agencies, on human rights issues such as those raised in the present case. Professor Yamin currently serves as a Commissioner on the Lancet-O'Neill Institute Commission on Global Health and the Law, the expert group of the UN High-Level Commission on Health Employment and Economic Growth, and the UN Secretary-General's Independent Accountability Panel for the Global Strategy for Women's Children's and Adolescents' Health. She previously served on World Health Organization Task Forces on Making Fair Choices Toward

Universal Health Coverage and on Evidence of Impacts of Human Rights-Based Approaches to Women's and Children's Health.

11. Through the end of 2015, Professor Yamin served on the Constitutional Implementation Committee of Kenya as the only non-Kenyan on the Oversight Committee regarding activities to implement health rights, thus bringing particular expertise to the matter before the Court. Professor Yamin has also been appointed by the Colombian Constitutional Court as an Independent Expert in implementing a landmark decision on the scope of that constitution's guarantee of a right to health. Professor Yamin has participated in the development of general comments and general recommendations in the UN treat body system, as well as provided expert guidance in relation to petitions on reproductive health in the Inter-American System of Human Rights, the UN Human Rights Committee, the UN Committee on Economic, Social and Cultural Rights, and the UN Committee on the Elimination of Discrimination Against Women.

12. The matter before this Court, insofar as it relates to the sexual and reproductive health rights of women living with HIV and raises questions arising from the rights afforded to women under the Constitution of Kenya, is directly related to Professor Yamin's work and to the mission of the FXB Center. Professor Yamin respectfully seeks to ensure that the Court is informed on the issues of reproductive rights relevant to this matter, considering the current state of international and comparative law as interpreted by courts and supra-national adjudicatory bodies elsewhere in the region and world.

III. APPLICATION OF INTERNATIONAL, REGIONAL, AND COMPARATIVE LAW

13. The argument below relies on international and regional agreements to which Kenya is a party, as well as comparative jurisprudence from other countries and international bodies which may be persuasive.

14. The Constitution of Kenya states that a "treaty or convention ratified by Kenya shall form part of the law of Kenya,"[1] and this Court has recognized that any rights contained in such conventions are thereafter recognized in Kenya unless otherwise inconsistent with the Constitution.[2] The Court has looked towards international law in interpreting constitutional rights even when there is no ambiguity necessitating such a consideration.[3] In keeping with these principles, the arguments below will rely on several international and regional conventions to which Kenya is a party, and draw on interpretations by courts or committees tasked with their enforcement.

15. Comparative constitutional law, while not binding in the instant case, also provides useful guidance as to both trends in law and frameworks for addressing similar fact patterns, as this Court has noted. In *Law Society of Kenya v The Centre for Human Rights and Democracy and Others*, Kiage JA approved considering foreign case law in issuing a decision, noting that "in this day and age of internationalization and globalization of law, there is little room for judicial insularity."[4] This is in keeping with the High Court's observation that "in its co-existence with others in the comity of nations," Kenyan courts should

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[1] Art 2(6), Constitution of Kenya (2010).
[2] *Wanjiku & Another v the Attorney General & Others*, Petition No. 190 of 2011, High Court at Nairobi, [2012] eKLR, para 21.
[3] *Karua v Radio Africa Ltd t/a Kiss F.M. Station & 2 Others*, Civil Suit 288 of 2004, High Court of Kenya at Nairobi, [2006] eKLR, 14.
[4] *Law Society of Kenya v The Centre for Human Rights and Democracy and Others*, Civil Appeal No. 308 of 2012, Court of Appeal at Nairobi, [2013] eKLR, 27.

consider even those legal agreements to which it is not itself a party,[5] and is also consistent with the approach that the Supreme Court has taken in similar situations.[6] The arguments below draw upon case law from domestic and regional tribunals which have considered questions similar to those before the Court today.

IV. ARGUMENT

16. The concept of intersectional discrimination is one that considers how different forms of discrimination, such as discrimination against women or against people living with HIV, interact with each other when an individual is part of both disadvantaged groups. Rather than merely being a tally of the effects of each type of discrimination, intersecting forms of discrimination influence and complicate each other. In other words, one cannot expect the discrimination faced by a woman living with HIV to simply be a "sum of parts" of the discrimination that women face and the discrimination that people living with HIV encounter. Rather, for the rights of these women to be advanced and for their dignity to be honoured, it is necessary to examine how their particular status as women living with HIV has impacted their lives in practice in the context of Kenya and their exercise of rights guaranteed under the Constitution.

17. Because of both the importance and sensitive nature of sexual and reproductive health, the UN has noted that women "belonging to particular groups," including people living with HIV, "may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health... Measures to guarantee non-discrimination and substantive equality should be cognizant of and seek to overcome the often exacerbated impact that intersectional discrimination has on the realization of the right to sexual and reproductive

[5] *Barasa v the Cabinet Secretary Ministry of Interior and National Coordinator and Others*, Constitutional Petition No. 488 of 2013, High Court at Nairobi, [2014] eKLR, para 44.
[6] *See, e.g., Trusted Society of Human Rights Alliance v Matemo and Others*, Petition No. 12 of 2013, Supreme Court of Kenya at Nairobi, [2014] eKLR, para 19.

health."[7] Because both gender and HIV status have a relationship to human sexuality, and as a result are frequently connected to biases and stigma, addressing intersectional discrimination faced by women living with HIV requires identifying both the ways in which people living with HIV are stigmatized and marginalized and the ways in which gender presents particular disadvantages to women living with HIV.

18. While the concept of sex is based in biology – namely, whether someone is identified as "male" or "female" based on the composition of their bodies – the concept of gender is different. Gender is a socially- and normatively-constructed notion, representing all of the assumptions that society makes based on differences in sex.[8] For example, the ability of women to have children is a sex-based distinction; a social expectation that women *should* have children – or should not – is a gender-based distinction. Stereotypes about women, or the subjugation of women to men, are based on the concept of gender that society has constructed. As such, they can also be deconstructed. Further, as this analysis will show, harmful stereotypes that interfere with the ability of women to pursue their life plans and participate as full members of society need to be challenged and replaced for a country to be in full compliance with international agreements.

19. As leading scholars, Rebecca Cook and Simone Cusack have argued that "[w]hen societies fail to recognize and eliminate [gender-based] prejudices and their associated stereotypes, that failure exacerbates a climate of impunity with respect to violations of women's rights. The climate of impunity enables prejudices and wrongful gender stereotypes to fester, causing further

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[7] Committee on Economic, Social and Cultural Rights, General Comment 22, E/C.12/GC/22 [advance unedited version] (2016), para 30.

[8] *See, e.g.,* Nancy Krieger, *Genders, Sexes, and Health: What Are the Connections – and Why Does It Matter?* International Journal of Epidemiology (2003), Volume 32, Issue 652-57, at 652-53; Pan American Health Organization, *Guidelines for Gender Based Analysis of Health Data for Decision Making*, (2010), 12.

devaluation of women."[9] If harmful gender-based stereotypes are allowed go unchecked, intersectional discrimination against women living with HIV will inevitably continue and undermine the possibility that these women could truly achieve effective enjoyment of their constitutional rights in practice.

20. To combat the pervasive role that gender-based stereotypes play in preventing equal rights for women, the Court can consider applying a three-step approach in this case. First, the Court can identify and explicitly articulate the stereotypes that underlie the sterilization of women living with HIV; second, the Court can determine if that practice imposes a burden on women's rights, diminishes their dignity, or subjects them to marginalization; and third, the Court can set out an alternative narrative about the dignity of women that promotes their empowerment rather than subjugation.[10]

21. Herein, it is proposed that sterilization without full and informed consent represents intersectional discrimination on the basis of HIV status and gender. Underlying stereotypes about women and, in particular, women living with HIV allow this discriminatory practice to persist, and deny women their fundamental rights. Thus, as will be shown, the Court is justified under both international law and the Constitution of Kenya to take action and to condemn this practice.

A. Sterilization without full and informed consent is inherently discrimination against women

22. Among people living with HIV, only women are targeted with sterilization either by performing sterilization surgery entirely without their knowledge or by using force, coercion, or nondisclosure of critical information to pressure women into having the procedure without actually granting full and informed consent. The

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[9] Rebecca Cook & Simone Cusack, *Gender Stereotyping: Transnational Legal Perspectives,* University of Pennsylvania Press (2011), 2.

[10] *Id.* at 2-3; *see also* Liiri Oja & Alicia Ely Yamin, *Woman in the European Human Rights System: How Is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?* (publication forthcoming).

type of sterilization allegedly used in the present case, bilateral tubal ligation (BTL), can only be used against women, and women are targeted for BTL because of their reproductive capacities and childrearing roles. This makes the practice inherently discriminatory on the basis of gender.

23. The World Health Organization (WHO) has observed that "women have been disproportionately subjected to forced, coerced, and otherwise involuntary sterilization,"[11] which they note has "been characterized as a form of discrimination and violence against women" by many human rights entities.[12] The WHO has unambiguously declared: "In making a decision for or against sterilization, an individual must not be induced by incentives [including from a] health-care provider or public officer."[13] The WHO further observed that "women living with HIV have been coerced to sign consent forms for sterilization procedures, as a condition of receiving antiretroviral and other HIV treatment and prenatal care for a current pregnancy, or other reproductive services," and that "[p]regnant women have also been asked to sign consent forms in situations of duress, such as during labour and while in severe pain... In these cases, the women have not been given information on the sterilization procedure, its permanent nature, or alternative methods of contraception."[14] In all of these situations, women may or may not have agreed to a sterilization procedure, but because they were not given full information, were offered an incentive if they agreed, or were asked to decide while in labour or otherwise under duress, full and free consent was not given and the procedure thus violated their rights. Furthermore, because women alone are the targets of such treatment, these scenarios also represent acts of discrimination.

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[11] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement*, (2014), 3.
[12] *Id.* at 1.
[13] *Id.* at 9-10.
[14] *Id.* at 4.

24. The Court itself has noted that health care practices that disproportionately impact women constitute discrimination. In *Omuya v the Attorney General & Others*, the High Court stated: "We have not, as a society, clearly internalized the fact that denial or neglect to provide interventions that only women need is a form of discrimination against women. As such, the lack of state provision or facilitation of access to affordable maternal health care, including delivery and post-natal care, is a facet of discrimination against women."[15] The Court added "that by failing to act on the practice of detention of women who are unable to pay for medical fees in respect of maternity services, the government discriminates against women as it is fully aware that it is only women who seek the services of institutions such as the 5th respondent to give birth. In failing to recognize and curb the practice, the state was in breach of its express obligation under CEDAW, Article 12 of which requires state parties to ensure that women have adequate services related to reproductive health."[16]

25. Reproductive rights include both entitlements that only women need, such as access to reasonable maternal care, and freedoms that only women need, such as the freedom to decide to have children as part of their life plans. need, such as the freedom to decide to have children as part of their life plans. Just it is discrimination to deny an *entitlement* that only women need (as this Court eloquently explained in *Omuya* with respect to maternal care), so too is it discrimination to deny protection of a *freedom* that only women need, herein the freedom to choose to have children.

26. As noted by the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, government intervention is necessary to prevent the infliction of inhuman or degrading treatment that disproportionately

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[15] *Omuya v the Attorney General & Others*, Petition No. 562 of 2012, High Court at Nairobi, [2012] eKLR, para 184.
[16] *Id.* at para 177.

affects women.[17] The Special Rapporteur has called upon states to pay particular attention to the needs of women who face intersectional discrimination and marginalization based on their other circumstances.[18] The Court can continue the crucially important work it began in *Omuya* by once again identifying and naming discrimination against women in the health care system.

27. The Court can also continue to draw on the findings of the case *Alyne da Silva Pimentel Teixeira v. Brazil*, decided by the Committee on the Elimination of Discrimination against Women (CEDAW Committee), the significance of which this Court noted in *Omuya*.[19] In *Alyne*, the CEDAW Committee rejected Brazil's argument "that measures to eliminate discrimination against women are considered to be inappropriate in a health-care system which lacks services to prevent, detect and treat illnesses specific to women," instead taking the position that the health care system *did* discriminate when it failed to protect lives with services that only women needed.[20] Involuntary sterilization should be seen as a parallel denial of a type of protection that only women require, thus making the practice discriminatory. The CEDAW Committee also found that there was "a causal link between Ms. da Silva Pimentel Teixeira's gender and possible medical errors committed,"[21] noting also that "the lack of appropriate maternal health services has a differential impact on the right to life of women."[22] There is a similar causal link between gender and involuntary sterilization, since the practice of BTL only happens to women, as a result of their biological reproductive capacity and socially-prescribed gender roles. The CEDAW Committee's rationale, adopted by this Court in *Omuya*, should therefore be extended to the practice of

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[17] Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/HRC/31/57 (2016), para 9.
[18] *Id.*
[19] *Id.* at para 186.
[20] *Alyne da Silva Pimentel Teixeira v. Brazil,* Communication No. 17/2008, Committee on the Elimination of Discrimination against Women, CEDAW/C/49/D/17/2008 (2011), para 7.6.
[21] *Id.* at para 7.3.
[22] *Id.* at para 7.6.

sterilization without full and informed consent by deeming it to be explicitly discrimination against women.

28. The Inter-American Commission on Human Rights (IACHR) is parallel to the African Commission on Human and People's Rights and supervises the American Convention on Human Rights, which has comparable protections against gender-based discrimination to those found in international and regional agreements that govern Kenya. The IACHR has explicitly found involuntary sterilization to represent discrimination against women. In *I.V. v Bolivia*, the IACHR stated "that many women in the Americas suffer damages to their right to personal integrity in the context of their access to health services and procedures that are exclusively needed by women because of their sex, their biological differences and their reproductive capacities. Accordingly, the IACHR has stated that States have an obligation to take positive steps to ensure the accessibility, availability, acceptability and quality of maternal health services, as a part of its obligations under the principle of equality and non-discrimination."[23]

29. Relevant to this case, the IACHR also noted that due to the history of discrimination against women and the permanence of involuntary sterilization, special care should be taken. The Commission explained that "[t]he greater the consequences of the decision to be adopted, the more rigorous the controls for ensuring the patient's free and informed consent," and that this is particularly true "when the surgical patient belongs to a population group that has traditionally been subject to exclusion or discrimination, as is the case of women, and in particular, the real of sexual and reproductive health."[24]

B. Gender-based stereotypes underlie the practice of non-elected sterilization

[23] I.V. v Bolivia, Report No. 72/14, Case 12.655, Inter-American Commission on Human Rights (2014), para 100.
[24] *Id.* at para 123.

30. Not only does sterilization without full and free consent amount to discrimination against women because it is a practice that only targets women and that denies only women fundamental rights, it is also discriminatory because it reflects deeply-embedded and harmful stereotypes about women and their role in Kenyan society. These stereotypes are used to justify withholding information about sterilization to women or using coercion to pressure them into underdoing sterilization, resulting in procedures done without full and informed consent and rather as a manifestation of societal bias.

31. Sadly, Kenyan women living with HIV face a lifetime of narrowing choices based on the stereotypes applied to them. They often contract HIV to begin with because women are not thought to have the right to choose their sexual partners, or to choose whether or not to use methods of sexual risk reduction, such as condoms. They are unable, as men are, to put aside their responsibilities as caretakers of their children, while at the same time lacking the choice to fully explore economic opportunities to be able to provide for their families. As a result, when they are offered free supplies to help feed and care for their babies contingent up on undergoing sterilization, they lack a meaningful capacity to decline.

32. The practice of sterilization without full and free consent in the health system takes the one area of choice that these marginalized women have left – whether or not to have children – and strips them of it. This practice reflects two harmful stereotypes about women living with HIV that will be explored herein: first, that women living with HIV do not have the capacity to care for their children and prevent HIV transmission, and second, that they do not deserve to have a choice regarding whether to have children.

33. The first stereotype reflected in the practice of sterilization that is done without full and informed consent is that women cannot be trusted to follow medical advice and regimens to safely bear children, or to care for their children in

general. The Kenya National Commission on Human Rights, in investigating abuses against Kenyan women living with HIV, found that the country has a systemic problem of "[f]orced sterilisation of HIV positive women with or without their knowledge," and cited the correlated fact "that widely there was a belief that women living with HIV should never bear children."[25] Another study conducted in Kenya found that only 58% of HIV counselors discussed with patients the implications that condom use would have on their ability to conceive children, and that 90% of people testing positive were not referred for family planning assistance, reflecting a "perceived inability of HIV patients to comprehend" the risks involved and to make an informed decision in the best interest of their family.[26] The WHO has observed: "In some instances, women living with HIV agree to sterilization on the basis of lack of information or misinformation about their reproductive options," which is the result of providers seeking to impose their opinion on women rather than informing them and allowing them to decide.[27]

34. The UN Committee on Economic, Social and Cultural Rights, in responding to the Kenyan government's latest report on conditions in the country, found that the law on sexual and reproductive rights is designed not to help women prevent HIV transmission to their children but rather to punish women whose children are born with HIV.[28] The fact that a mother would be imprisoned if she transmitted HIV to a child reflects a system of blaming and shaming women for their perceived failures as mothers, rather than one that helps women to achieve their goal: having and raising healthy children. The Committee urged Kenya to "intensify its efforts to combat the spread of HIV/AIDS, including MTCT [or

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[25] Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Rights in Kenya: A Myth or Reality?*, (April 2012), 115.

[26] Shalini Bharat & Vaishali Sharma Mahendra, *Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers*, Reproductive Health Matters (2007), Volume 15, Issue 29 (Supplement), 99.

[27] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement*, (2014), 3.

[28] Committee on Economic, Social and Cultural Rights, Concluding Observations on the Combined Second to Fifth Periodic Reports of Kenya, E/C.12/KEN/CO/2-5 [advance unedited version] (2016), para 55.

mother-to-child transmission], by effectively implementing relevant national policies, strategies, guidelines and programs."[29] As suggested by the Committee, it is the health care system's job to care for women and children, not to further stereotype by shaming them for having children with HIV.

35. The stereotype of women with HIV not being responsible mothers is not based on medical science. The WHO has found that motherhood is generally safe for women living with HIV, but that providers are largely biased against these women and misinformed about the facts.[30] For example, the Center for Reproductive Rights reports that there is only a two percent chance of mother-to-child transmission when the necessary steps are taken to prevent infection.[31] Nevertheless, two-thirds of the women interviewed for that report were told by their health care providers that women living with HIV should not bear children, and half were actively discouraged from having children themselves.[32] The stereotype also runs counter to the reality that women living with HIV still value motherhood as being an option for their lives. According to Professor Sofia Gruskin, "Research results have indicated that when women are asked if a positive HIV status would impact on their decision to bear children, they have made clear that it would not."[33] The idea of women living with HIV being ineligible for motherhood thus reflects neither scientific data nor the lived experience and expectations of the affected women.[34]

36. The stereotype that women living with HIV cannot be trusted to follow medical advice often persists even when women have demonstrated adherence to HIV regimens and have sought out assistance in ensuring a safe pregnancy and

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[29] *Id.* at para 56.
[30] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement*, (2014), 3-4.
[31] Center for Reproductive Rights, *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities* (2010), 25.
[32] *Id.*
[33] Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights*, American University Law Review (April 1995), Volume 44, 1193-94.
[34] *See* Emily Esplen, *Women and Girls Living with HIV/AIDS: Overview and Annotated Bibliography* (February 2007), 16.

delivery. The WHO has found that this is because providers are often driven by biases and poor information about HIV transmission, rather than fairly assessing a woman's options and risks and allowing her to make an informed decision.[35]

37. The second stereotype reflected in the practice of sterilization without full and informed consent is that women are incapable or undeserving of making their own decisions about whether or not to have children. Under this view, women are merely instruments of childbearing and, just as it is someone else who decides when they should have children, it is also acceptable for a social worker or health care provider to decide that they should not have children.

38. When women are not viewed as capable of making responsible choices about fundamental decisions, and are not viewed as deserving agency over their lives, they are dehumanized and stripped of their basic human dignity. For example, the Kenya National Commission on Human Rights has cited a representative of Women Fighting HIV and AIDS in Kenya as reporting "an American funded organisation in western part of Kenya that is coercing women to accept USD 40 as compensation to agree to undergo sterilisation in order to meet the UNAIDS slogan of Zero number of children born with HIV."[36] If true, women's lives are being instrumentalized to meet other objectives. The same dynamic is at work whenever women are considered unfit to make their own decisions about having children.

39. Professor Sofia Gruskin, in examining the choice of women living with HIV to be mothers, has found that "in many cultures, an essential dimension of the expectations for a woman's sense of personal satisfaction or self-esteem is the value placed on pregnancy."[37] There is thus a double burden to the stereotype

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[35] World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement*, (2014), 3-4.
[36] Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Rights in Kenya: A Myth or Reality?* (April 2012), 116.
[37] Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights*, American University Law Review (April 1995), Volume 44, 1193-94.

that women are merely vessels of bearing children: they are at once expected to be mothers in order to offer value to society, but also face the possibility of motherhood being stripped from them.

40. This stereotype of women, while having a specific Kenyan context in the case before the Court, is in many ways cross-cultural. The IACHR, in ruling against Bolivia in a case of involuntary sterilization, noted that "the persistence of gender stereotypes in health services results in women being denied certain abilities – such as the capacity to autonomously make decisions concerning their health."[38]

41. The IACHR continued, "[T]he Commission considers that in the instant case there are signs that the medical team that performed the surgery on [Petitioner] I.V. was influenced by gender stereotypes on the ability of women to make autonomous decisions with respect to their own reproduction. The medical decision to practice sterilization without I.V.'s informed consent reflects a notion that medical personnel are empowered to take better decisions than the woman concerned regarding control over reproduction. Accordingly, the Commission considers that the presence of these kinds of gender stereotypes in the actions of health personnel has a different impact on women than on men and leads to the former being discriminated against in health services and especially in the delivery of sexual and reproductive health care services. On this, the Commission has previously highlighted that ongoing gender stereotypes in the health sector act as an obstacle to women's access to maternal health services, which also amounts to discrimination in women's access to health."[39]

42. The IACHR also pointed to a 2012 Colombian case about access to contraception, which found that the denial of information and informed choice to women perpetuates the cycle in which they are perceived to be incapable of

[38] I.V. v Bolivia, Report No. 72/14, Case 12.655, Inter-American Commission on Human Rights (2014), para 131.
[39] *Id.* at para 162.

fulfilling this role.[40] The Constitutional Court of Colombia explained that "one of the mechanisms for perpetuating the historical discrimination experienced by women has been, and continues to be, precisely, to deny or hinder the access to accurate and impartial information on this subject with the objective of denying them control over these types of decisions."[41]

43. The same findings were also made in a case against Peru. In a settlement with a woman who was forcibly sterilized there, the government admitted that ending the practice of involuntary sterilization will require "eliminating any discriminatory approach and respecting women's autonomy," rather than accepting that women's decisions should be made for them.[42]

44. As will be discussed below, the Court has an opportunity in this case to name and debunk these destructive stereotypes, replacing them with a view that accords with universal human rights and the emancipatory promises of the Kenyan Constitution: "women, literate or illiterate, rich or poor, given the information and the right to choose and decide, will make the right decisions for themselves and their families, and for the community at large."[43]

C. Harmful stereotypes are embedded in the health system through the practice of sterilization without full and free consent, which is a denial of fundamental rights and dignity

45. Sterilization without full and informed consent embeds the harmful stereotypes noted herein and in doing so reproduces them. Rather than being a space in which women can claim their full citizenship and evade the discrimination that

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[40] *Id.* at para 133, citing Judgment T-627-12, Constitutional Court of Colombia (2012).
[41] *Id.*
[42] *Mestanza Chavez v. Peru*, Report No. 71/03, Petition 12.191, Inter-American Commission on Human Rights (October 2003), 7.
[43] Rebecca J. Cook, Bernard M. Dickens, and Mahmoud F. Fathalla, *Reproductive Health and Human Rights*, Clarendon Press (2003), 39; *see also* Nisha Anand et al, *Bridging the Gap: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion* (2009), 9.

pervades the rest of society, the health system perpetuates the degradation these women face in the larger society and in so doing violates their human rights.[44] These rights, recognized under both Kenyan and international law, include the rights to health, family planning, bodily integrity, dignity, and freedom from degrading and inhuman treatment.

46. The Constitution of Kenya states, "Every person has inherent dignity and the right to have that dignity respected and protected."[45] It further recognizes the right of all people to not be "subjected to any form of violence from either public or private sources,"[46] a statement that reaffirms the government's duty to protect citizens from such violence. It also recognizes the right of all Kenyans to not be "treated or punished in a cruel, inhuman or degrading manner."[47]

47. This Court has noted the inseparability of this right to dignity and the right to health, stating in *Omuya*, "The right to health and the right to dignity are inextricably related. In providing health care of acceptable quality, health care institutions must respect the dignity of their patients."[48] As examples of affronts to dignity that were present in the health care system, the Court cited "being treated rudely," "being treated... with contempt," and "being forced to sit on a bench for a period of time while... bleeding."[49] Noting that one of the petitioners "was rushed to theatre without being informed of what procedure she was to

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[44] *See* Alicia Ely Yamin & Fiona Lander, *Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights*, Journal of Human Rights (2015), Volume 14, 312-31, at 321-22 (state obligations regarding vulnerable populations' access to health care, and how respect or lack thereof of dignity can "redefine who is considered a full human being and equal member of society"); Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why They Matter*, University of Pennsylvania Press (2016), 104 ("the importance of health systems derives not merely from the delivery of services but also from the way citizens interact with the health system"); *id.* at 105 (the "understanding of what measures should be taken to achieve equality derives from this basic idea of the health system as part of the foundation of our society, which can exacerbate inequalities and exclusion or facilitate the conditions under which all people can live with equal dignity").

[45] Art 28, Constitution of Kenya (2010).

[46] Art 29(c), Constitution of Kenya (2010).

[47] Art 29(f), Constitution of Kenya (2010).

[48] *Omuya v the Attorney General & Others*, Petition No. 562 of 2012, High Court at Nairobi, [2012] eKLR, para 127.

[49] *Omuya v the Attorney General & Others*, Petition No. 562 of 2012, High Court at Nairobi, [2012] eKLR, para 128.

undergo," this Court concluded that the actions were "a violation of her inherent right to dignity," the effect of which was to "strip her of her self-worth."[50] Involuntary sterilization represents a similar violation in which the damage done to women – both to the body and to the sense of dignity – is permanent.

48. The UN Committee on Economic, Social and Cultural Rights has stated that the international right to health extends beyond the mere absence of disease and includes "effective protection from all forms of violence, torture and discrimination and other human rights violations that negatively impact on the right to sexual and reproductive health."[51] It is well-established in international human rights law that sterilization without full and informed consent does exactly that, and violates the right of women to live with dignity and to be free of inhuman treatment. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has unambiguously declared: "Forced sterilization is an act of violence and a form of social control, and violates a person's right to be free from torture or ill-treatment. Full, free and informed consent of the patient herself is critical and can never be excused on the basis of medical necessity or emergency when obtaining consent is still possible."[52] The Special Rapporteur has found that sterilization not meeting these conditions violates the rights to life and dignity and amounts to inhuman and degrading treatment,[53] regardless of whether it is done by physical force, without full understanding and consent, or with economic coercion, such as when "health workers promise women food and clothing if they agree to undergo sterilization."[54]

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[50] *Id.*

[51] Committee on Economic, Social and Cultural Rights, General Comment 22, E/C.12/GC/22 [advance unedited version] (2016), para 7.

[52] Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment*, A/HRC/31/57 (2016), para 45.

[53] Economic and Social Council, *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Ms. Radhika Coomaraswamy, in Accordance with Commission on Human Rights Resolution 1997/44, Addendum: Policies and Practices that Impact Women's Reproductive Rights and Contribute to, Cause, of Constitute Violence against Women,* E/Cn.4/1998/68/Add.4 (1999), para 44-45.

[54] *Id.* at para 51-52.

49. In addition to the immediate indignity of having their bodies violated by an unwanted medical procedure, sterilization without full and informed consent violates the dignity of women for the rest of their lives. The ability to choose to create a family is among the most fundamental and well-established of human rights. It is not only critical to the individual, but also the society. The Constitution of Kenya explicitly recognizes this fact in noting that "[t]he family is the natural and fundamental unit of society and the necessary basis of social order, and shall enjoy the recognition of and protection of the State."[55] Sterilization without full and informed consent undermines this critical human right, and the constitutional order that the Court is bound to uphold.

50. Women should be recognized as full and equal members of Kenyan society whether or not they choose to have children. However, because motherhood is still seen as a critical part of a woman's role in marriage, taking away a woman's ability to have children often destabilizes her relationships, families, and finances. In a tragic irony, many women are economically coerced into undergoing sterilization – as the Kenya National Commission on Human Rights found in citing the example of a health care provider paying women to be sterilized, as noted above[56] – only to emerge from the procedure to face increased socioeconomic marginalization. This reflects findings that "[a] woman's fertility or potential fertility can also influence her status in the community and in her own family, as well as be key to her economic survival."[57] Researchers at the University of Toronto studying the issue of sterilization have also found that ability to have children is essential to many women's opportunity for survival, and that "many women, therefore, may not forgo reproductive opportunities where the condition of maintaining marital, de facto, or transactional sexual, unions is seen essential

[55] Art 45(1), Constitution of Kenya (2010).
[56] Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Rights in Kenya: A Myth or Reality?* (April 2012), 116.
[57] Sofia Gruskin, *Negotiating the Relationship of HIV/AIDS to Reproductive Health and Reproductive Rights*, American University Law Review (April 1995), Volume 44, 1193-94.

to women's economic and physical security."[58] While the long-term goal of society should be to increase women's opportunities beyond merely having children, in the immediate term it must be recognized that taking away this ability from women prevents them from living a secure, dignified life.

51. Women who are sterilized without free and full consent are sometimes subjected to social stigma, isolation, and spousal abandonment as a result of their being unable to bear more children. Even the fear of such outcomes can have a significant negative effect on a woman's health and wellbeing. This was reflected in a series of cases in which the European Court of Human Rights (ECtHR) found that involuntary sterilizations had violated women's right to dignity under the European Convention on Human Rights.[59] These cases were brought by Roma women, who represent a particularly marginalized and disfavored minority group, against the government of Slovakia. In one case, the ECtHR found that the petitioner had endured severe "difficulties in her relationship with her partner" and that the woman "cited her infertility as one of the reasons for her divorce in 2009."[60] The ECtHR added that the "sterilisation had resulted in the deterioration of her relationship with the father of her children and impaired her standing in the Roma community."[61]

52. The ECtHR decisions are also instructive in demonstrating how the context of sterilization occurring against a disfavored group was important in contributing to the denial of those women's dignity. "The sterilisation had not been a life-saving procedure," the ECtHR noted, and "had been carried out without consideration for alternative ways of protecting her from the alleged risks linked to a possible future pregnancy, such as the various methods of contraception available to her

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[58] Nisha Anand et al, *Bridging the Gap: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion* (2009), 6.
[59] N.B. v Slovakia, Application No. 29518/10, European Court of Human Rights (June 2012); V.C. v Slovakia, Application No. 18968/07, European Court of Human Rights (August 2012); I.G. and others v Slovakia, Application No. 15966/04, European Court of Human Rights (April 2013).
[60] V.C. v Slovakia, Application No. 18968/07, European Court of Human Rights (August 2012), para 118.
[61] *Id.* at para 134.

and her husband which would not have left her permanently infertile."[62] Rather, the ECtHR explained that the sterilization procedure had "to be seen in the context of the widespread sterilising of Roma women,"[63] much as the context of sterilization of women living with HIV must be seen in the context of such practices targeted specifically at women with HIV. The ECtHR concluded that "[t]he nature of the procedure as such and the circumstances in which it had been carried out amounted to inhuman and degrading treatment contrary to Article 3 of the [European] Convention," finding in favor of the petitioners.[64] The ECtHR thus found the Slovakian government had failed to protect women's fundamental rights in the health system.

53. Importantly, the ECtHR also made clear that involuntary sterilization is a violation of the right to dignity even if that was not the intent of the medical provider. They wrote that "[a]lthough the purpose of such treatment is a factor to be taken into account, in particular the question of whether it was intended to humiliate or debase the victim, the absence of any such purpose does not inevitably lead to a finding that there has been no violation of Article 3" of the European Convention on Human Rights, which bans degrading treatment.[65]

54. Adopting this rationale, the Court in the present case would not need to determine that the intent of the health care providers or social workers was malicious to find that the right to dignity of the sterilized women had been violated in the event they did not fully consent. Sterilization without full and informed consent, regardless of the alleged rationale under which it is performed, reflects the harmful stereotypes about women's lack of capacity to make choices enumerated above, and strips women of their basic rights and dignity as equal human beings.

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[62] *Id.* at para 89.
[63] *Id.* at para 90.
[64] *Id.* at para 91.
[65] *Id.* at para 101.

D. Condemning sterilization without full and informed consent is an important way in which the Court can advance the promises of the Kenyan Bill of Rights

55. The Court itself noted in the *Omuya* case that "the people of Kenya gave to themselves a very expansive Bill of Rights, the purpose of which was to ensure the social transformation that they have been yearning for."[66] Applying this specifically to the issue of reproductive health, the Court explained that Kenya "has a constitutional and international law obligation with respect to ensuring that its citizens have access to the highest attainable standard of health, and specifically with respect to women, that they have access to reproductive health care... Despite these obligations placed on the state under national and international law... a large number of women do not benefit from the protection afforded under the Constitution and international law."[67]

56. The Constitution, in establishing a right to health, specifically notes the importance of reproductive health care, declaring: "Every person has the right... to the highest attainable standard of health, which includes health care services, including reproductive health care."[68] The Constitution also establishes: "Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres."[69] Not only are individuals banned from discriminating directly or indirectly on the basis of sex or health status,[70] but the government is required to "take legislative and other measures... designed to redress any disadvantage suffered by individuals or groups."[71]

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[66] *Omuya v the Attorney General & Others*, Petition No. 562 of 2012, High Court at Nairobi, [2012] eKLR, para 68.
[67] *Id.* at 141-42.
[68] Art 43(1)(a), Constitution of Kenya (2010).
[69] Art 27(3), Constitution of Kenya (2010).
[70] Art 27(7), Constitution of Kenya (2010).
[71] Art 27(6), Constitution of Kenya (2010).

57. Read together, these rights should be interpreted as requiring the State of Kenya to take proactive steps to eliminate discrimination in health, in addition to ensuring on a case-by-case basis that private entities do not discriminate on the basis of sex or health status. Not only is discrimination in receiving health care unconstitutional as a matter of discrimination, it also prevents the government from fulfilling its obligation to help all Kenyans reach the highest attainable standard of health. Further, the health of the most vulnerable of Kenya's population – such as women living with HIV – should receive special consideration from the Court in light of the Constitution's explicit instruction that it consider "the vulnerability of particular groups or individuals" in deciding how the government should enable citizens to most fully enjoy their rights.[72]

58. Kenya National Commission on Human Rights has written of the health care system's "need to promote the sexual and reproductive health rights as provided for in the Constitution of Kenya 2010," explaining that it "will encourage women to freely come out and voluntarily test for HIV and disclose their status publicly."[73] Of particular relevance to the instant case, the Commission stated its view that "PMTCT," or care to prevent mother-to-child transmission of HIV, "must be provided to all women who require it to prevent vertical mother to child infection during delivery."[74] Yet the health care system has not done this. Moreover, by sterilizing women living with HIV, it is inflicting lifelong harm on the very population to whom it is supposed to be offering treatment.

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[72] Art 20(5(b)), Constitution of Kenya (2010).
[73] Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Rights in Kenya: A Myth or Reality?* (April 2012), 148.
[74] *Id.*

59. Given the transformative vision of the Constitution and the rights it guarantees, it would be a missed opportunity for the Court not to use this case to create public learning with respect to the meaning of constitutional rights to the lives of the most vulnerable members of society. The actions of other tribunals have demonstrated that when there is a failure to analyze constitutional guarantees in a gender-sensitive way regarding sterilization, the impact of the court's decision is significantly weakened. For example, the Supreme Court of Namibia in 2012 ruled in favor of women living with HIV who had been involuntarily sterilized, but did so solely on the basis that it was an inappropriate medical action based on the lack of consent.[75] The Court explicitly refused to speak as to the issue of discrimination and the relevance of that nation's constitution.[76] In doing so, it may have punished the perpetrators of those instances of sterilization, and perhaps discouraged this indefensible practice in the future. However, it did little to address the underlying social and gender dynamics that allowed the problem to exist: the stereotypes about women living with HIV, the discrimination women with HIV face in society, and the lack of attention given to their suffering and denial of dignity within the health system.

60. This Court can have a far greater impact on both narrative explication under the Constitution and on people's rights in practice by adopting the view that intersectional discrimination that is inseparable from the sterilization without consent alleged in this case, and by taking the three-step approach to naming, analyzing, and dismantling gender stereotypes undermining this practice.

E. Condemning sterilization without full and informed consent affirms Kenya's compliance with international law

61. The Court has an opportunity in ruling on sterilization without full and informed consent to demonstrate that it is not only in compliance with human rights law

[75] LM, MI, and NH v Government of the Republic of Namibia, Case No. SA 49/2012, Supreme Court of Namibia (2014), para 109.
[76] *Id.* at para 2.

and the international agreements to which Kenya is a party, but also to provide a model for other judiciaries in the interpretation of these rights and for the insistence on their protection in practice.

62. The Universal Declaration of Human Rights (UDHR), the foundational document of international human rights law, is – like the Constitution of Kenya – aspirational in nature. Article 28 declares: "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized."[77] Those "rights and freedoms" include to live in a society free from discrimination on the basis of sex or other factors,[78] to be free from inhuman or degrading treatment, [79] and "to found a family," which is declared "the natural and fundamental group unit of society... entitled to protection by society and by the state."[80] In noting "the right to a standard of living adequate for the health and well-being" of each individual, the UDHR states that "[m]otherhood and childhood are entitled to special care and assistance."[81]

63. Importantly, the UDHR also promises "the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him [or her] by the constitution or by law."[82] The UDHR thus envisioned a world in which all people have an equal claim to freedom and dignity, and in which the state – and in particular the courts – are the guardians of that freedom, ensuring a progression towards fuller recognition of rights and lives of dignity for all.

64. Since the adoption of the UDHR in 1948, the global commitment to and understanding of the requirements for equal dignity and access to health for women has exponentially grown. The International Covenant on Economic, Social and Cultural Rights (ICESCR) calls for "[t]he widest possible protection and

[77] Art 28, Universal Declaration of Human Rights (1948).
[78] Art 2, Universal Declaration of Human Rights (1948); Art 7, Universal Declaration of Human Rights (1948).
[79] Art 5, Universal Declaration of Human Rights (1948).
[80] Art 16, Universal Declaration of Human Rights (1948).
[81] Art 25(1), Universal Declaration of Human Rights (1948).
[82] Art 8, Universal Declaration of Human Rights (1948).

assistance [to] be accorded to the family," and in particular to maternal care,[83] of which the Court took note in *Omuya*.[84] ICESCR requires further that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth,"[85] yet the sterilization practices alleged here actually target women living with HIV with unwanted, degrading care during the sensitive and critical time around childbirth. State parties to ICESCR, including Kenya, also acknowledge the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health,"[86] which includes freedom from unwanted, unnecessary, and non-consensual procedures.

65. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to which Kenya is a party, proclaims: "State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, equal access to health care services, including those related to family planning."[87] As illustrated above, when women alone are targeted for sterilization on the basis of their HIV status, it is a clear violation of this right.

66. CEDAW's prohibition on discriminatory practices is broad, requiring States parties "[t]o take all appropriate measures... to modify or abolish laws, regulations, customs *and practices* which constitute discrimination against women."[88] State parties thus do not satisfy their commitment under CEDAW merely by having an absence of laws that formally discriminate against women.

67. Importantly, CEDAW not only requires action against instances of discrimination themselves but also requires "the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of

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[83] Art 10, International Covenant on Economic, Social and Cultural Rights (ratified 1976).
[84] *Omuya v the Attorney General & Others*, Petition No. 562 of 2012, High Court at Nairobi, [2012] eKLR, para 27.
[85] Art 10(2), International Covenant on Economic, Social and Cultural Rights (ratified 1976).
[86] Art 12, International Covenant on Economic, Social and Cultural Rights (ratified 1976).
[87] Art 12(1), Convention on the Elimination of All Forms of Discrimination against Women (ratified 1984).
[88] Art 2(f), Convention on the Elimination of All Forms of Discrimination against Women (ratified 1984) (emphasis added).

either of the sexes or on stereotyped roles for men and women."[89] The CEDAW Committee has further elaborated that this requires action against the "prevailing gender relations and the persistence of gender-based stereotypes that affect women," and the underlying "legal and societal structures and institutions."[90] Thus, the powerful stereotypes and intersectional discrimination against women living with HIV described above must be named explicitly as the violations they are and challenged

68. In *Alyne,* the CEDAW committee explained Brazil's obligation to improve maternal health conditions for women, which is relevant to the instant case and can be summarized as follows:

    a. Even when a private provider is involved, the state is ultimately responsible for health care services because at the very least it should be monitoring closely and making sure that the minimum standard is met.

    b. When health care system fails to meet the specific needs of women, or has a differential impact on their lives, that amounts to discrimination.

    c. Policies that affect marginalized groups of women and represent intersectional discrimination (e.g., in the present case, women living with HIV) should be subject to even greater scrutiny.

    d. The state must ensure that there is a process for those who are wronged to seek redress, and it must make systemic change to address violations.[91]

69. Just as the *Alyne* decision has already proven influential in Kenya, it has also been applied to the lives of women living with HIV elsewhere in the world. The

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[89] Art 5(a), Convention on the Elimination of All Forms of Discrimination against Women (ratified 1984).
[90] General Recommendation No. 25, on Article 4, Paragraph 1, of the Convention to Eliminate All Forms of Discrimination against Women, on Temporary Special Measures, UN Doc. A/59/38 (2004), para 7.
[91] *Alyne da Silva Pimentel Teixeira v. Brazil,* Communication No. 17/2008, Committee on the Elimination of Discrimination against Women, CEDAW/C/49/D/17/2008 (2011), para 7.5-7.8.

Inter-American Court of Human Rights (IACtHR), citing the CEDAW Committee's work in *Alyne*, found that Ecuador violated the rights of a woman living with HIV for failing to have an adequate system to provide her with both prevention and treatment services.[92] Furthermore, because the woman had been met with discrimination in nearly every facet of her life on the basis of her HIV status and gender, the IACtHR found that Ecuador had failed not only to prevent the individual action but also, importantly, to address the underlying social dynamics as required under international law.[93]

70. Finally, at the regional level, Kenya is also bound by the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Relevantly, the Maputo Protocol requires states to guarantee women "the right to respect as a person,"[94] to "implement appropriate measures to prohibit any exploitation or degradation of women,"[95] and to ensure for each women "respect for her dignity and protection... from all forms of violence."[96]

71. Notably, in requiring states to ensure the right to health for all women, the Maputo Protocol specifically requires states to recognize "the right to decide whether to have children" and "the right to *choose* any method of contraception."[97] Perhaps more clearly than any other agreement, the Maputo Protocol requires states not to infringe on a woman's decision to have children or to not have children; the choice, in either instance, is the woman's and the woman's alone to make. Any practice that would remove a woman's agency to decide to have children and to place that decision in the hands of a third party is

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[92] Center for Reproductive Rights, *Government of Ecuador Fails to Protect the Rights of People Living with HIV* (24 Sept. 2015), *available at* http://www.reproductiverights.org/pressroom/governmentofecuadorfailstoprotecttherights-ofpeoplelivingwithhiv

[93] *Id.*

[94] Art 3(2), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ratified 2010).

[95] Art 3(3), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ratified 2010).

[96] Art 3(4), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ratified 2010).

[97] Art 14(1), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ratified 2010) (emphasis added).

thus clearly inconsistent with obligations under the Maputo Protocol. But such a denial of a woman's reproductive rights also offends provisions regarding discrimination under the African Charter and Maputo Protocol, which are compounded by the intersectional nature of that discrimination when based on stereotypes about women living with HIV and a deep societal prejudice against them.

V. CONCLUSION

72. For the reasons outlined above, it is submitted that:

a. The sterilization of women living with HIV must be viewed critically in light of the biases associated with these women and their powerlessness to avoid unwanted sterilization procedures, thus making the practice not one of the free and full consent required by Kenyan and international law.

b. Like the health care practices condemned in *Omuya*, the issue of sterilization without full and informed consent converts the nurturing and caring for one's new child into a time of deep humiliation, subjugation, and denial of human dignity.

c. When the practice of sterilization without full and informed consent is targeted at women living with HIV, it constitutes a form of intersectional discrimination based on harmful gender stereotypes, and converts the health system into a facilitator and exacerbator of such violations of dignity, rather than a core social institution that fosters substantive equality and democracy, in particular for vulnerable Kenyan women and children.

d. In light of the foregoing, the Court can and should utilize its constitutional authority to condemn the practice of sterilization without free and informed consent as an affront to dignity, a violation of rights to health

and to have a family, and as intersectional discrimination against women living with HIV.

e. Dialogue among the branches of government and serious structural changes will be needed to ensure that the Court's decision has a lasting effect, and the Court can play a role in this process by requiring that the government report on its progress.

f. In taking this position on sterilization, the Court can demonstrate that Kenya is not only in compliance with international treaties to which it is a party but is also a role model, in step with the trends in international law and comparative constitutional jurisprudence. Importantly, it will also be upholding the constitutional commitment "to nurturing and protecting the well-being of the individual, the family, communities, and the nation."[98]

DATED at 18th **this day of** July **2016**

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[98] Preamble, Constitution of Kenya (2010).

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