REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT NAIROBI

MILIMANI LAW COURTS

CONSTITUTIONAL AND HUMAN RIGHTS DIVISION

PETITION NO. 27 OF 2022

RACHAEL MWIKALI.....1ST PETITIONER

ESTHER AOKO.....2ND PETITIONER

AMBASSADOR FOR YOUTH & ADOLESCENT REPRODUCTIVE HEALTH PROGRAMME (AYARHEP).....3RD PETITIONER

KENYA LEGAL AND ETHICAL ISSUES NETWORK ON HIV & AIDS.....4TH PETITIONER

VERSUS

CABINET SECRETARY

MINISTRY OF HEALTH .....1ST RESPONDENT

THE ATTORNEY GENERAL.....2ND RESPONDENT

AND

KENYA OBSTETRICAL

GYNAECOLOGY SOCIETY.....1ST INTERESTED PARTY

KARIBA INSTITUTE.....2ND INTERESTED PARTY

KENYA CHRISTIAN PROFESSIONALS FORUM...3RD INTERESTED PARTY

JUDGMENT

Background

1. In 2017, the Ministry of Health (the 1st respondent) commenced the process of redrafting the National Reproductive Health Policy (the Policy) in conjunction with other stakeholders including the Council of Governors. In September 2021, the 4th petitioner was invited by the Council of Governors for stakeholder consultation on the draft policy, which the 4th petitioner attended on 17th September 2021 and presented oral submissions. The meeting was an engagement with the Council of Governors but not the 1st respondent.

2. On 5th October 2021, the 4th petitioner with other Human rights organizations wrote to the head of the Reproductive and Maternal Health Division seeking to be included and give input in the drafting process. The 4th petitioner further highlighted key issues to be addressed in the draft policy but did not receive a response.

3. In a letter dated 1st March 2022, the Ministry of Health indicated that the Reproductive and Maternal Health Division in collaboration with partners had revised several reproductive health documents and was moving to the next stage of printing, launching and disseminating documents at the national and county levels to facilitate implementation within various reproductive health programmes. The national launch was tentatively scheduled for 23rd March 2022.

4. The 4th petitioner and other organizations responded to the letter and expressing discontent and called for urgent steps to ensure adequate and meaning public participation before the launch and operationalization of the policy. They also pointed out that the policy should be aligned with the Constitution. On 22nd March 2022, a coalition for grassroots human rights defenders led by the 1st petitioner delivered a petition to the 1st respondent's office demanding community involvement in the formulation and validation process of the policy.

5. Following that action the Ministry sent out an invitation to a meeting to be held on 6th April 2022 to deliberate on the draft policy. The 4th petitioner attended the meeting and highlighted a few key issues, such as lack of a guiding framework for safe abortion care, among others.

6. The 1st respondent again invited stakeholders for a meeting on 25th April 2022 for a workshop on the draft policy which the 4th petitioner attended. The 1st respondent promised to consider submissions by participants and share the updated version of the draft policy together with the matrix of comments and responses and host a validation meeting prior to the launching of the Policy document, which however did not happen.

7. Later on, (On 28th June 2022), the 1st respondent sent out an invitation for a validation meeting to be held on 1st July 2022. Due to short notice coupled with what the petitioners said was the 1st respondent 's refusal to provide the policy document to be

validated, various stakeholders, including the 1st and 4th petitioners did not attend. The petitioners indicated that those who attended said the validation meeting was not participatory but a dress down from Dr. Stephen Kaliti, Head of the Reproductive and Maternal Health Division. The 4th petitioner wrote a letter of protest to the 1st respondent and disengaged itself from the process leading to the launch of the policy on 5th July 2022.

Petitioners' case

8. The petitioners filed this petition against the Cabinet Secretary, Ministry of Health and the Attorney General, (the respondents) contending that the policy is unconstitutional because its formulation did not meet the threshold for public participation; its provisions undermine the right to life and reproductive health.

9. The petitioners asserted that the policy uses exclusionary language that denies critical reproductive healthcare interventions to the majority of women and girls. The petitioners took issue with Clauses 2.3.3; 3.4.2 and 4.2.3- paragraph 6 of the policy because they demonstrate bias towards family to the detriment of the rest of the population of reproductive age. According to the petitioners, clause 2.3.3 draws data on the use of modern contraceptives from a population of married women while clause 3.4.2 focuses on the provision of family planning for couples that have achieved their desired family sizes. Clause 4.2.3 recognises the central role of the family in the reproductive health.

10. The petitioners stated that the policy excludes adolescent women and young girls from benefiting from reproductive health as it envisages provisions of cervical cancer screening services for women between 25-49 years only. The policy further limits interventions from healthcare workers with regard to accessing safe abortion because it requires that termination of pregnancy

be performed based on the opinion of a trained health professional with the proficiency to ensure both the mother and the unborn child receive the highest attainable standard of healthcare.

11. The petitioners asserted that healthcare interventions under the policy are discriminatory against young women below 21 years because they are denied access to reproductive health services on grounds that they have not attained full cognitive competence on matters of sexuality and reproduction. The petitioners contended that by making a blanket intervention, the Ministry failed to give regard to both facts and evidence on teenage pregnancies and HIV and AIDS infections thus, the policy contradicts other laws and policies.

12. According to the petitioners, it is unreasonable for the policy to require parental consent prior to provision of reproductive health services and fails to provide guidelines for instances where

parental or guardian consent cannot be procured. The policy also fails to consider the legal age of majority and seeks to unconstitutionally limit an adult's ability to consent to their own healthcare services.

13. The petitioners maintained that the policy excludes unmarried women from fertility treatment and places a mandatory requirement that all pregnant women and their families to be tested for HIV thereby creating a barrier for access to critical maternal healthcare and commodities and the right to privacy, dignity and adequate healthcare.

14. The petitioners also took issue with Clause 3.4.12 for not only limiting the rights of intersex persons but also discriminating against intersex persons who do not wish to have assignment of sex into the "correct sex." They faulted Clause 4.2.3 paragraph 8 on the basis that it makes the Director General for Health the custodian of all reproductive health research thus, usurping the

mandate of the National Commission on Science, Technology and Innovation.

15. The petitioners asserted therefore that the policy violates articles several articles of the Constitution, including 10 (2) (a), 24, 26 (1) and (4); 27; 33; 35; 43 (1) (a); 53 (1) (c) ,232 (1) (d) and 232 (2); section 15 and 68 of the Health Act, 2017; sections 28(3), 146 and the First Schedule to the Children's Act, 2022; sections 4 and 5 of the Access to Information Act; sections 6 and 7 of the Science Technology and Innovation Act; sections 22, 23, 34 and 35 of the East African Community HIV and AIDS Prevention and Management Act; Policy Guideline 2 of the Public Service Commission Guidelines for Public Participation in Policy Making, 2015 and article 14 of the Maputo Protocol.

16. According to the petitioners, the gaps and economic barriers in provision of safe and accessible health services lead young girls to seeking reproductive health services in unsafe environment. Informal settlements have high levels of sexual violence and

teenage pregnancies which lead to unsafe abortion and many negative outcomes for women.

17. They stated that on 6th April 2022, the Ministry held a meeting to deliberate on the Policy at the Emory Hotel in Kileleshwa which the 1st petitioner attended and made contributions on lack of meaningful engagement, exclusion of community views and disregard of scientific data and facts. According to the petitioners, a director at the Ministry (Dr. Andrew Mulwa), later admitted shortcoming in undertaking meaningful public participation and promised that the Ministry would ensure that time set aside to undertake community engagement which did not happen.

18. The petitioners stated that on 18th April 2022, the Ministry invited partners to attend a workshop on the policy on 25th April 2022 in Mombasa but the 1st petitioner did not attend the meeting because the notice was short. On 1st July 2022, the 4th petitioner informed the 1st petitioner that the Ministry was holding a

validation meeting at Emory Hotel in Kileleshwa. The 1st petitioner sent a representative to the meeting while she tried to join the meeting online in vain. The policy was launched on 5th July 2022 but some of the petitioners were not invited to attend and witness the launch.

19. The 2nd petitioner admitted that on 31st March 2022, the Ministry sent out an invitation for a meeting to deliberate on the policy to be held on 6th April 2022 at Emory Hotel in Kileleshwa, Nairobi which she attended. Various participants also attended. Participants from the civil society highlighted the fact that the draft policy was missing interventions thus, it would be detrimental to healthcare provisions for women and girls.

20. On 18th April 2022, the 2nd petitioner received invitation from the Ministry to attend a workshop over the policy between 25th April 2022 and 29th April 2022 at Pride Inn Flamingo Resort

Mombasa. During the workshop, participants made various contributions on the retrogressive aspects in the draft policy.

21. The drafting process concluded on 28th April 2022 and representatives from the Ministry and the participants agreed that the Ministry would consider and incorporate suggestions given and share the updated version of the draft policy together with the matrix on comments and responses and host a validation meeting on 29th April 2022, which was not done.

22. The 2nd petitioner stated that the Ministry sent out an invite on 28th June 2022 for a meeting scheduled for July 2022 to validate policy. The 2nd petitioner attended the meeting but stated that she was unable to meaningfully participate because the draft policy had not been shared and the notice was too short. The validation meeting was not participatory but a dress down from one Dr. Stephen Kaliti. On 5th July 2022, the 1st respondent launched the policy thus, the issues raised in the petition.

23. Just like the other petitioners, the 4th petitioner reiterated the concerns raised in the petition. According to the 4th petitioner, the push to move the age of sexual debut from 18 to 21 years is without any scientific evidence and is contrary to the laws and policies that allow minors to consent to their own reproductive health services. By requiring parental consent before children receive reproductive healthcare services, the policy limits the ability of healthcare workers to provide services to adolescents based on their evolving capacities.

24. The petitioners asserted that the policy conflicts with various existing guidelines that healthcare providers rely on in providing healthcare services. The policy contains clauses that will serve as barriers to reproductive healthcare service provision for all Kenyans and particularly women, children, intersex persons and other vulnerable community populations.

25. The petitioners also took issue with Clause 3.4.8 paragraph 7 on the premise that Linda Mama is not anchored in law; remains vulnerable to inadequate implementation and its financing is subject to political goodwill. In their view, the policy should address the Linda Mama Programme wholesomely as it is inadequate because the requirements for registration lock out those unable to prove citizenship, especially those who reside in marginalized and remote areas. The programme also locks out adolescents who may require critical reproductive healthcare services but do not have access to a guardian in a timely manner.

26. The petitioners asserted that provision of reproductive healthcare services relating to termination of pregnancy such as abortion and post abortion care is unclear since the policy uses a non-medical and non-scientific and inaccurate definition of abortion.

27. Regarding Clause 3.4.1 at paragraph 12, the petitioners asserted that the requirement that Health professionals terminate a pregnancy taking into account the health of both the mother and the unborn child is confusing and unclear especially on the definition of the term abortion. This may result in unwarranted barriers to women in need of abortion and post abortion care as it creates an environment of fear and ambiguity.

28. The petitioner maintained that clause 3.4.4 requiring that all pregnant women and their families be tested for HIV, the petitioner asserted that it may present a barrier to accessing comprehensive antenatal care services for patients who may fear seeking these services due to coercion. There is no mention of what reproductive health care interventions that children living with HIV should be afforded, particularly as they transition into adolescence and through to adulthood.

29. The petitioners contended that the procedure set out at Clause 3.4.12 paragraph 3 on intersex persons is ambiguous and unclear as it does not specify what professional body the intersex persons are required to present themselves before. Further, the policy direction does not envision a situation where an intersex person may have no desire to undergo transition and chooses to live as intersex throughout their lives. It was also contended that paragraph 5 introduces bureaucracy into the registration of children born with ambiguous genitalia by providing that these births be reported or notified to a government health facility. It does not also provide a solution to the systemic discrimination in registration of intersex persons at birth and creates further differentiation without justification.

30. The petitioners were of the view, that Clauses 3.4. 13 and 4.2.3.8 at paragraph 5 shun the role county governments play in promoting diversity by providing for the mainstreaming of reproductive health research.

31. Based on the above concerns, the petitioners sought the following reliefs:

i. *A declaration do hereby issue that the process arrived at in developing the National Reproductive Health Policy 2022-2032 violated the right to meaningful public participation guaranteed in articles 10(1) & 10 (2) (a), 35 and 232 (1) (d) of the Constitution as read together with section 15 of the Health Act and the Public Service Commission Guidelines for Public Participation in Policy Making, 2015.*

ii. *A declaration do hereby issue that the fundamental right to life and the right to the highest attainable standard of health including reproductive healthcare as envisaged by articles 26(1) and (4), 27, 35, 43 (1) (a), 53 (1) (c)of the Constitution as read together with section 34 (1) (a), 34 (2)(b) and 35 of the East African Community HIV Prevention and Management Act, 2012 and sections*

5, 6, 7 and 68 of the Health Act, 2017 and section 5 of the Access to Information Act encompass access to sexual and reproductive health services, information and commodities for all Kenyans.

iii. *A declaration that the Reproductive Health Policy 2022-2032 violates the right to reproductive health as provided under articles 26 (4), 27, 35, 43 (1) (a), 53 (1) (c) of the Constitution as read together with section 21, 22, 34 (1) (a), 34 (2) (b) and 35 of the East African Community HIV Prevention and Management Act, 2012 and sections 5, 6, 7 and 68 of the Health Act, 2017 and section 5 of the Access to Information Act.*

iv. *A declaration that the Reproductive Health Policy 2022-2023 violates the rights of children under article 53(1) (c) and (2), as read with section 16 (2) (3) and (4) of the Children Act in the manner it limits the provision of reproductive health interventions to adolescents.*

v. *A declaration do issue that the Reproductive Health Policy 2022-2032 violates article 33 on the right to freedom of expression, including academic freedom and freedom of scientific research as read with sections 6 and 7 of the Science and Technology Act, 2013.*

vi. *A mandatory order do issue barring the respondents from implementing the Reproductive Health Policy 2022-2032 in so far as the same is contrary to the constitutional principle of public participation and a violation of article 10 (1) & 10(2) (a), 35 and 232 (1) (d) and restricts the right to health under article 43 (1)(a), 26 (4) and 53(1) (c) of the Constitution.*

vii. *In addition to or in the alternative to prayer (vi), a mandatory order do issue suspending the implementation of clause 2.3.3, clause 2.3.7,clause 3.4.1 paragraph 12, clause 3.4.2, clause 3.4.4 paragraph 2, clause 3.4.8 paragraph 1, clause 3.4.8 paragraph 8, clause 3.4.11 paragraph 5 and 6, clause 3.4.12 paragraph 1,3 and*

5, clause 3.4.13 paragraph 2, and clause 4.2.3.8 paragraph 5 of the Reproductive Health Policy 2022-2032 in so far those provisions violate the right to highest attainable standard of health under article 43 (1) (a), 26(4) and 53 (1) (c) of the Constitution.

viii. *A mandatory order do issue compelling the respondent to within 30 days of this order, review the National Reproductive Health Policy 2022-2032 and conduct this review together with the petitioners, relevant stakeholders and members of the public in order to consider all views of interested and affected parties.*

ix. *A structural interdict do issue compelling the 1st respondent to report back to this Honourable Court every 45 days to confirm compliance with order (viii) above.*

x. *The Honourable Court do issue any further orders, directions and remedies as it may deem fit and just in the circumstances.*

xi. There be no orders as to costs.

Responses

Respondents' responses

32. The respondents opposed the petition through a replying affidavit sworn Dr. Patrick Amoth. The respondents stated that the Reproductive Health Policy developed in 2007 needed to be reviewed to align it with the changed legal framework and the Constitution, 2010. In line with its mandate in accordance the Ministry initiated a review of the policy in 2016 through a comprehensive public exercise, stakeholder engagement and existing laws and policies.

33. The respondents maintained that there was comprehensive public participation an cited as an example, the Council of Governors' letter dated 11th September 2020; the letter by the Cabinet Secretary for Health dated 4th November 2020; the

technical directive by the Ministry dated 19th October 2020; a joint Reproductive Health Policy consultative meeting held at Lake Naivasha Resort on 20th and 21st November 2020 and a publication summit held from 20th April to 25th April 2022 at Pride Inn Flamingo, Mombasa.

34. It was the respondents' position that the right to safe and legal abortion in exceptional circumstances is articulated in article 26(4) of the Constitution and a guiding framework is necessary to ensure access to safe abortion services provided by trained medical personnel.

35. The respondents maintained that decisions on sex and reproduction are complex and developmental competence is only attained well over the age of 21. It is therefore the role of policies to protect children before that maturity and competence is achieved. Moreover, policies facilitating liberal sex among or with children offend any rational science behind the promotion and

protection of the health of a child or adolescent and facilitate the triple threat of HIV and sexually transmitted infections, premature childhood pregnancies and sexual abuse of children.

36. The respondents asserted that the petitioners' desire to exclude parental consent on behalf of children is against section 16(1) of the Children Act, which provides that "*Every child shall have the right to the highest attainable standard of healthcare services in accordance with Article 43 of the Constitution: Provided that the provisions of reproductive health services to children shall be subject to the express consent of the parent or guardian.*"

37. The respondents asserted that while there has been a push to include Comprehensive Sexuality Education in the policy, such a course would undermine the government's desire to develop a culturally acceptable and competency-based age-appropriate education material on sexually reproductive health for minors.

38. The respondents maintained that the Policy extensively addresses universal unfettered access to quality post abortion care for all and enforces the right to quality healthcare without discrimination. The respondents denied the petitioners' claim that there is discrimination in the provision of Assisted Reproductive Technology. According to the respondents, Assisted Reproductive Technology is a medical intervention for treating infertility. They maintained that they complied with the law in coming up with the policy.

1st interested party's response

39. Kenya Obstetrical Gynaecology Society, the 1st interested party supported the petition through a replying affidavit sworn by its president Dr. Kireki Omanwa. The 1st interested party asserted that it was not adequately involved in the drafting of the policy.

40. According to the 1st interested party, the policy is incoherent and does not align itself with other critical policies aimed at strengthening reproductive health frameworks in Kenya, specifically- Kenya-AIDS Strategic Framework II 2020-2024; National Adolescent Sexual and Reproductive Health Policy-2015; Standards and Guidelines for Reducing Morbidity and mortality for unsafe Abortion in Kenya-2012; National Guidelines on Management of Sexual Violence-2014; National Guidelines for Provisions of Adolescent Youth-Friendly Services (YFS) in Kenya (2005); National AIDS and STI Control Program (NASCOP)and Adolescent Package of Care in Kenya; A Health Care Provider Guide to Adolescent Care (2014).

41. The 1st interested party contended that the requirement for mandatory HIV/AIDS testing is not in line with the provisions of section 2 and 4 of the HIV and AIDS Prevention and Control Act, 2006; the National Guidelines for HIV Testing and Counselling in Kenya, Ministry of Public Health and Sanitation (2008); the National Guidelines for Management of Sexual Violence in

Kenya 2014; the National Adolescent Sexual and Reproductive Policy 2015 and the National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya (2006).

42. Section 2 of HIV and AIDS Prevention and Control Act, 2006 is an interpretative section while section 4 requires the government to promote awareness about the causes, modes of transmission consequences, means of prevention and control through comprehensive nationwide education and information campaign through its various forums.

43. The 1st interested party asserted that the policy makes limited or no reference to other legal frameworks and contradicts current policy positions. The policy does not make reference to article 26(4) of the Constitution which permits safe legal abortion under limited circumstances. The policy further fails to acknowledge the progressive pronouncements in the decision of *Federation of Women Lawyers (Fida-Kenya) & 3 others v Attorney General & 2 others; East Africa Centre for Law & Justice & 6 others (Interested*

Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] KEHC 6928 (KLR) and *PAK and another v Attorney General & 3 others [2022] KEHC 262 (KLR).*

44. The 1st interested party further stated that the policy fails to differentiate between safe abortion and unsafe abortion and does not address the challenges of unsafe abortion in Kenya because of the uncertainty in health policies regarding when healthcare providers can legally provide abortion services. The policy does not also align itself with the Sexual Offences Act and the National Guidelines for Management of Sexual Violence in Kenya, 2014.

45. The 1st interested party maintained that using consistent terminology in health policies is essential for clear and effective communication as well as ensuring that policies are properly and uniformly implemented across different settings. On the other hand, inconsistent terminologies lead to confusion,

misunderstanding and inconsistencies in policy implementation with a negative impact on the health and well-being of individuals and communities.

46. The 1st interested party urged for the removal of the definition of "Crisis" in the policy for being inaccurate, misinforming and not applicable within the parlance of reproductive health and maternal healthcare. The definition further contradicts the provisions of Article 8 of the Constitution.

47. According to the 1st interested party, the policy restriction on access to sexual and reproductive health information for individuals under the age of 21 undermines the principle of confidential, independent healthcare access for young people. By limiting access to critical information and services, the policy fails to address the urgent needs of young people and instead increases their vulnerability to adverse health outcomes.

48. It was the 1st interested party's position that requiring parental involvement when youth seek sensitive healthcare services is counterproductive. The 1st interested party was of the view, that as best practice, an adolescent with the unbiased scientifically accurate and evidence-based guidance of a trained health professional, be allowed to give consent for all types of healthcare and to have their confidentiality in the provision of that care, as it is essential that adolescents have access to confidential health care.

2nd interested party's response

49. The 2nd interested party also supported the petition through a replying affidavit sworn by Christine Nkonge. The 2nd interested party agreed with the petitioners that this court has jurisdiction to determine whether the policy is consistent with the Constitution; the 1st respondent was required to consult county governments; the Policy limits the provision on reproductive healthcare

interventions to adolescents; creates discrimination based on marital status; the provisions of reproductive fertility treatment to infertile couples restricts the provisions of fertility treatment to all persons and cervical cancer screening and reproductive health services to those above 21 years is discriminatory.

50. The 2nd interested party further supported the petitioners' position that information concerning reproductive health services is important information that affects individuals and the nation. Any information concerning the development of reproductive health service policies should have been proactively disclosed under article 35(3) of the Constitution and section 5 of the Access to Information Act. The 2nd interested party also agreed that the policy violates freedom of expression, including academic freedom and freedom of scientific research.

3rd interested party's response

51. The 3rd interested party on its part opposed the petition through a replying affidavit sworn by Dr. Wahome Ngare. The 3rd interested party agreed with the respondents on the need to review the previous policy.

52. Regarding public participation, the 3rd interested maintained that there was exhaustive public participation and had interacting with the draft policy in a technical meeting of retreat between 8th -11th October 2019 held in Naivasha. The meeting included medical experts in Paediatrics, Obstetrics and Gynaecology, the Ministry of Health technical departments, Community Service Organizations and international partners, among others.

53. In September 2020, the Council of Governors asked for more time and was requested to present I submissions from counties. The request for further extension of time was again accepted in November 2020. In the same month, the Ministry sought further public participation and engagements with Civil Society

organizations and called for more submissions to improve the policy.

54. On 10th November 2020, the Department of Health and Sanitation of Kisumu County summitted its memorandum on the Policy. Another meeting was called by the Council of Governors to include Members of Health Committee of the Council of Governors, Members of Health Committees of both Houses of Parliament was held on 28th September 2021 at Enashipai Resort in Naivasha. The two levels of government held a joint consultative meeting over the policy at Lake Naivasha Resort on 20th and 21st November 2021.

55. On 2nd February 2022, a meeting of Council Technical Officers took place. The Ministry led several consultative forums on the draft policy and engaged multiple stakeholders between 2020-2022. On 31st March 2022, the Ministry invited reproductive health stakeholders and heads of civil societies involved in reproductive

health to a meeting held on 6th April 2022 at the Emory Hotel. A copy of the policy was also shared.

56. The 3rd interested party was represented and participated in the meeting of 6th April 2020 in which there emerged different schools of thoughts, the "Pro-life" and Pro-family group" and the "Sexual and Reproductive Health and Right" group. It was agreed that each of the two groups nominates five persons and together with technical experts from the Ministry and partners, hold a meeting to thrush out the contentious issues. As a follow up to the resolutions reached on 6th April 2022, a meeting was held from April 20th-25th April 2022 at Pride-inn Flamingo Resort in Mombasa. The meeting had the Ministry's technical team, representatives from civil society organizations, professional associations and societies, including the 1st interested party, Kenya Medical Association, an organization representing sex workers and lesbians, an organization representing intersex persons, religious organizations and independent commissions, including

Commission for Administrative Justice and the Kenya National Human Rights Commission, among others.

57. The 3rd interested party stated that the two sides reached a compromise and validated most of the document. On 21st June 2022, a Brief was submitted to the Cabinet Secretary, highlighting key issues that evoked divergent positions. On 5th July 2022 the Policy as launched. The 3rd interested party maintained that the policy was formulated with the involvement of all relevant stakeholders.

58. The 3rd interested party took the position that the term sexual reproductive health right is contentious and highly divisive since it is not used in the Constitution. It is also inconsistent with the law and moral values, especially the right to life, the family as the primary unit of society and parental rights over their children. The 3rd interested party asserted that the import of article 26(4) of the Constitution is to restrict abortion to the opinion of a trained health professional.

Submissions

59. The petition was disposed of through written submissions with brief oral highlights.

Petitioner's submissions

60. The petitioners submitted, highlighting their written submissions, that the 1st respondent's failure to facilitate meaningful public participation in the formulation and adoption of the Policy violated articles 10 and 232 (1) (d) of the Constitution and section 15 of the Health Act; the Public Service Commission Guidelines for Public Participation in Policy Making, 2015 and article 12 of the International Covenant on Economic, Social and Cultural Rights.

61. The petitioners relied on *Robert N. Gakuru & Another v Governor Kiambu County & 3 others* [2014] eKLR to submit that public participation has to be meaningful and real. They maintained that the process was done without the involvement of relevant stakeholders.

62. The petitioners argued that the manner in which the policy was adopted violated article 35 of the Constitution and section 4 of the Access to Information Act because the 1st respondent refused to make the draft policy available to the petitioners and the general public to facilitate a meaningful and transparent public participation in its development. The petitioners relied on the decisions in *Katiba Institute v Presidents Delivery Unit & 3 others* [2017] eKLR; *Okiya Omtatah Okoiti v Commissioner General, Kenya Revenue Authority & 2 others* [2018] eKLR; Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the highest attainable Standard of Health, UN Doc. E/C. 12/ 2000/4 para 11 and General Comment No. 22 (2016)

on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights).

63. The petitioners again argued that the policy violates articles 43 (1) (a) and 53 (1) (c) of the Constitution in that it undermines access to lawful termination services in article 26 (4) of the Constitution by considering the rights of the unborn child instead prioritizing the health and wellbeing of the mother. They relied on the decision in *Federation of Women Lawyers (FIDA-Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested arty) & Women's Link Worldwide & 2 others (Amicus Curiae)* (supra).

64. The policy is also discriminatory contrary to article 27 of the Constitution and sections 34 and 35 of the East African Community HIV Management Act, because it requires that contraceptive services be provided only to women in family unions.

65. The policy violates the rights of children guaranteed under article 53(1)(2) as read with section 16 (2)(3) (4) of the Children Act by limiting provision of reproductive health intervention to adolescents thereby impeding access to reproductive health care services to women under the age of 21 and requiring parental consent for girls under the age of 18 for all reproductive health interventions. The policy does not also align itself with the National Guidelines for the Provision of Adolescent and Youth Friendly Services, 2016.

66. The petitioners argued that while it is desirable for parents to support adolescents in accessing reproductive healthcare, the policy requirement that healthcare be denied in the absence of parental consent causes unconstitutional harm to adolescents because it deprives them life sustaining health care services; locks out the vulnerable and marginalized adolescents many of whom may be competent and may not have a parent or guardian or where there is an emergency.

67. The petitioners maintained that the policy impedes access to information to young people by precluding anyone under 21 years and prohibiting the rights of children under the age of 18 from accessing sexual and reproductive health services, including reproductive health information. They relied on the CESCR General Comment No 16.

68. The petitioners again argued that the policy limits freedom of scientific research and violates sections 6 and 7 of the Science, Technology and Innovation Act and the role of the National Commission on Science, Technology and Innovation. They relied on the decision in *Robert Alai v Attorney General* [2017] eKLR and submitted that the policy violates article 24(1) of the Constitution.

69. The petitioner again relied on article 23(3) of the Constitution and the decisions in *Daniel Ng'etich & 2 others v Attorney General & 3 others* [2016] eKLR; *Mohamed Ali Baadi and others v Attorney General & 11 others* [2018] eKLR and *Mitu Bell Welfare*

Society v Kenya Airports Authority & 2 others; Initiative for Strategic Litigation in Africa (Amicus Curiae) [2021] eKLR and urged the court to allow the petition.

Respondents' submissions

70. The respondents submitted also highlighting their written submissions, that the policy formulation complied with the requirements on public participation. They relied on *William Odhiambo & 3 others v Attorney General & 4 others; Muslims For Human Rights & 2 others (Interested Parties)* [2021] eKLR; *Independent Electoral and Boundaries Commission (IEBC) v National Super Alliance (NASA) Kenya & others* [2017] eKLR; *Robert N. Gakuru & Others v Governor Kiambu County & 3 others* [2014] eKLR and *Doctors for Life International v Speaker of the National Assembly & Others* (CCT12/05) [2006] ZACC 11.

71. The respondents argued that public participation may take different forms and may at times include consultations. They

relied on the decisions in *Legal Advice Centre & 2 others v County Government of Mombasa & 4 others* [2018] eKLR and *Mui Coal Basin Local Community & 15 others v Permanent Secretary Ministry of Energy & 17 others* [2015] eKLR.

72. According to the respondents, consultation or stakeholders' engagement gives more latitude to key sector stakeholders in a given field to take part in the process towards making laws or formulation of policies and administrative decisions which impact on them. That is because such key stakeholders are mostly affected by the law, policy or decision in a profound way. For that reason, in appropriate instances a government agency or a public officer undertaking public participation may consider incorporating the aspect of consultation or stakeholders' engagement which the 1st respondent did.

73. The respondents again relied on *Matatiele Municipality and Others v President of the Republic of South Africa and Others (2)* (CCT73/05A) [2006] ZACC 12; and *Poverty Alleviation Network*

& Others v President of the Republic of South Africa & others, CCT 86/08 [2010] ZACC 5 for the submission that the 1st respondent sought public views and ensured that there was necessary stakeholder involvement.

74. The petitioners maintained that the process underwent elaborate public participation and involvement at every stage to ensure that it was aligned with government priorities and policy direction on reproductive health matters.

75. Regarding safe abortion services, the respondents cited article 26 (4) of the Constitution and the decision in *PAK & another v Attorney General & 3 others* [2022] eKLR and the Human Rights Committee General Comment Number 36 on abortion. On parental consent in relation to the procurement of reproductive health care services for minors, the respondents relied on section 16 (1) of the Children Act.

76. Regarding HIV testing, the respondents submitted that the policy seeks to eliminate mother to child transmission so that

required services are sought and offered to all, including mothers to protect children from acquiring HIV or the negative outcome which is in the best interest of children.

77. The respondents submitted that the inclusion of data specifically on married women in the policy was not intended to discriminate against unmarried women but was meant for consistency purposes. They contended that while the policy highlights the modern contraceptive prevalence rate for married women as an indicator of progress, the same surveys collect data for both married and unmarried women and have always included information on the contraceptive needs and preferences or unmarried women. They asserted that all reproductive health care services in Kenya, including family planning are delivered with a clear mandate of equity.

78. All in all the respondents submitted that the policy complied with legal requirements in its formulation and its provisions are aligned

with the Constitution and the law. They urged the court to dismiss the with costs.

1st interested party's submissions

79. The 1st interested party largely reiterated the contents of its affidavit and relied on the decision in *Association of Kenya Medical Laboratory Scientific Officers v Ministry of Health & another* [2019] eKLR on the importance of policies, standards and guidelines for healthcare providers. The 1st interested party argued that the policy is unconstitutional thus, a new policy should be formulated in line with the Constitution, existing laws, policies and standards.

2nd interested party's submissions

80. The 2nd interested party submitted relying on articles 10(1), (2)(a) and 232 (1) (d) of the Constitution and the decisions in

British American Tobacco Kenya v Cabinet Secretary for the Ministry of Health & 2 others; Kenya Tobacco Control Alliance and another (Interested Parties); Mastermind Tobacco Kenya Limited (The Affected Party) [2019] eKLR; *Nairobi Metropolitan PSV Saccos Union Limited & 25 others v County of Nairobi Government & 3 others* [2014] eKLR; *Association of Kenya Medical Laboratory Scientific Officers v Ministry of Health & another* [2019] eKLR and *National Assembly & another v Okiya Omtatah Okoiti & 55 others* [2024] KECA 876 (KLR), that there was no meaningful public participation.

81. The 2nd interested party associated itself with the petitioners' submission that the 1st respondent violated the right of access to information by refusing to make the draft policy available to them and the general public to facilitate a meaningful and transparent public participation.

82. The 2nd interested party relied on article 35 (3) of the Constitution, section 5(1) (c) of Access to Information Act and the

decision in *Nairobi Law Monthly Company Limited v Kenya Electricity Generating Company& 2 others* [2013] eKLR to argue that the State is required to publish and publicise any information affecting the nation. Failure to do so impacted on the petitioners' right to participate in good governance through public participation.

83. The 2nd interested party argued that the policy expressly denies provisions of information on reproductive health services to anyone under 21 years of age thereby unjustifiably limiting that category's right to reproductive health rights. The 2nd interested party asserted that some adolescents are within the reproductive age and require information on the services available to them.

84. Regarding article 26(1) and (4) of the Constitution, the 2nd interested party argued that prioritizing the highest standard of health for both the mother and the unborn child is unconstitutional. According to the 2nd interested party, the text of the Constitution and jurisprudence are clear that the life of the

mother takes precedence within the scope of article 26 (4) of the Constitution. The addition of words "life of the child" in the policy is *ultra vires* the requirement in the Constitution. Reliance was placed on *Kelly Malenya v Attorney General & another; Council of Governors (Interested Party)* [2019] eKLR.

85. Regarding article 43 (1) of the Constitution, the 2nd interested party cited article 21(2) of the Constitution and article 12 of the ICESCR to contend that in failing to lay out a policy framework which adequately addresses health needs of the youth, women and other marginalised populations, the respondents violated those groups' constitutional rights to the highest attainable standard of health.

86. The 2nd interested party relied on the decision in *Tatu Kamau v Attorney General & 2 others; Equality Now & 9 others (Interested Parties); Katiba Institute & another (Amicus Curiae)* [2021] KEHC 450 (KLR) to argue that the right to the highest attainable standard of health includes the right to health care

services, such as reproductive health care for every person, a right that is also included in international treaties and covenants such as the East African Community HIV and AIDS Prevention and Management Act. The policy violates the right to the highest standard of health of those in the 18–21- bracket by depriving them of their right as adults to make their own decisions regarding their health.

87. The 2nd interested party again submitted that the policy violates the right to highest standard of health of women by requiring pregnant women and their families to take HIV test. The HIV Prevention and Control Act prohibits compelling individuals to undergo HIV test both in general and as a prerequisite for the provisions of healthcare. The 2nd interested party relied on section 13(1), (2) of the HIV Prevention and Control Act 2006 and the decision in *PAK and another v Attorney General and 3 others* (supra).

88. On discrimination, the 2nd interested party cited article 27 (1)(4) of the Constitution, section 6 of the Health Act, section 34 (1) (a) of the East African Community HIV and AIDS Prevention and Management Act and the decisions in *Prinsloo v Van der Linde and Another* (CCT4/96) [1997] ZACC 5; *Federation of Women Lawyers Kenya (Fida-K) & 5 others v Attorney General & another* [2011] eKLR and *Harksen v Lane NO* and Others (CCT9/97) [1997] 12, among others, to argue that the policy discriminates based on marital status by prioritizing reproductive health solutions to married couples at the expense of the rest of the population. This is also the case when the policy uses statistical samples from married populations rather than from the general population concerning contraception and referring to married couples in the context of infertility.

89. The 2nd interested party associated itself with the petitioners' position concerning cervical cancer screening and limiting reproductive health care services those below 21 years as well as the fact that the policy usurps the mandate of the Independent

National Commission on Science, Technology and Innovation. The 2nd interested party relied on articles 24(1) and 33 (1) (c) of the Constitution; sections 6 and 7 of the Science Technology and Innovation Act and the decision in *Sorguc v Turkey,* ECtHR, 23 June 2009, No 17089/03, the European Court of Human Rights (ECtHR).

3rd interested party's submissions

90. The 3rd interested party supported the position taken by the respondents. The 3rd interested party argued that there was meaningful public participation; involvement and engagement as required by article 10(2) (a) of the Constitution and section 6 of the Health Act. The 3rd interested party relied on the decisions in *Kaps Parking Limited & another v County Government of Nairobi & another* [2021] eKLR; *Legal Advice Centre & 2 others v County Government of Mombasa & 4 others* (supra) and *Mui*

Coal Basin Local Community & 15 others v Permanent Secretary Ministry of Energy & 17 others (supra).

91. The 3rd interested party asserted that denying an unborn child the right to life is an infringement and a violation of the unborn child's right to life protected under article 26(1), (2) of the Constitution. The 3rd interested party relied on the decision in *PAK & another v Attorney General & 3 others* (supra).

92. The 3rd interested party argued that minors do not have the requisite capacity to make decisions on matters concerning reproductive health and therefore the need for parental consent. It was the 3rd interested party's position that by virtue of section 16 (1) of the Health Act, the requirement for parental consent for girls under the age of 18 who need reproductive health intervention is sound in law and in the best interest of the child.

93. The 3rd interested party refuted the petitioners' claim over violation of the right of access information maintaining that the ministry acted in compliance with the constitutional and statutory

requirements on the right of access information. The 3rd interested party relied on the decisions in *Famy Care Ltd v Public Procurement Administrative Review Board & another & 4 others* [2012] eKLR and *Katiba Institute v President's Delivery Unit & 3 others* [2017] eKLR.

94. The 3rd interested party again relied on sections 107, 108 and 109 of the Evidence Act and the decision in *Anarita Karimi Njeru v Republic* [1979] eKLR on evidential burden and urged the court to dismiss the petition.

Determination

95. Upon considering the pleadings and arguments by parties, the following issues arise for determination. First, whether there was meaningful and effective public participation and second, whether the policy violates rights and freedoms, the Constitution or the law.

Public participation

96. The petitioners argued that there was no meaningful and effective public participation during the formulation and development of the policy. They also argued that they were not given the policy document for purposes of public participation a violation of article 35 of the Constitution, a position that was supported by the 1st and 2nd interested parties.

97. The respondents maintained that there was meaningful and effective stakeholders' engagement and participation as required by the Constitution. They also denied violating the right of access to information since the policy document was given out to parties. The respondents' position was supported by the 3rd interested party.

98. Public participation is one of the founding values in our Constitution. Article 10 contains values and principles of

governance, the soul of the nation, which include participation of the people. Article 10 (1) also provides in firm and clear language that national values and principles of governance bind all State organs, State officers, public officers and all persons whenever any of them—applies or interprets the Constitution; enacts, applies or interprets any law; or makes or implements public policy decisions.

99. Formulation, enactment and implementation of policy is one of the actions that require engagement and participation of the people. In that respect, there was no argument that public involvement and participation was not required in the case of the impugned policy. The issue is whether there was public involvement and participation and, if so, whether it was meaningful and effective. The petitioners and 1st and 2nd interested parties argued that there was no meaningful and effective public participation while the respondents maintained that there was effective public engagement and participation, a position supported by the 3rd interested party.

100. The extent to which public participation is required has been the subject of litigation in this country on many occasions and courts have made pronouncements on the extent of public participation required. From those decisions, including persuasive foreign decisions, the law is now settled that public participation or involvement should be real and effective and not an illusory. People must be given an opportunity to make their views known on the issue and their views should be capable of influencing the legislative or public policy decisions.

101. In *Robert N. Gakuru & others v Kiambu County Government & 3 others* [2014] eKLR, the court stated that *"public participation ought to be real and not illusory and ought not to be treated as a mere formality for the purposes of fulfilment of the Constitutional dictates."* The court emphasised that the spirit of public participation should be attained both quantitatively and qualitatively.

102. At the Court of Appeal, (*Kiambu County Government & 3 others v Robert N. Gakuru & Others* [2017] eKLR), the Court of Appeal affirmed the High Court decision, stating:

> *[20]...The issue of public participation is of immense significance considering the primacy it has been given in the supreme law of this country and in relevant statutes relating to institutions that touch on the lives of the people. The Constitution in* **Article 10** *which binds all state organs, state officers, public officers and all persons in the discharge of public functions, highlights public participation as one of the ideals and aspirations of our democratic nation.*

103. The Court of Appeal went on to assert that public participation must include, and be seen to include, the dissemination of information, invitation to participate in the process and consultation on the legislation [or other process]. That is, people must be accorded an opportunity to participate in the legislative process, a fact to be proved by the party that was required to

comply with this constitutional requirement that indeed there was compliance.

104. Addressing the same issue in *Minister for Health v New Chicks South Africa Pty Ltd* (CCT 59/2004) [2005] ZACC 14; the Constitutional Court of South Africa observed that the forms of facilitating an appropriate degree of participation in the law-making process are of infinite variation. *"What matters is that at the end of the day, a reasonable opportunity is offered to the members of the public and all interested parties to know about the issue and to have an adequate say."*

105. In the words of Ngcobo, J. in *Doctors for Life International v Speaker of the National Assembly & Others* (CCT 12/05) [2006] ZACC 11, *"merely allowing public participation in the law-making process is not enough. More is required and measures need to be taken to facilitate public participation."*

106. In *Matatiele Municipality and Others v President of the Republic of South Africa and Others (2)* (CCT73/05A) [2006] ZACC 12, Ngcobo J cited the decision in *Doctors For life* for the position that what is ultimately important is that the legislature (or body responsible) has taken steps to afford the public a reasonable opportunity to participate effectively in the process. The court pointed out that there are at least two aspects of the duty to facilitate public involvement: The duty to provide meaningful opportunities for public participation in the process and the duty to take measures to ensure that people have the ability to take advantage of the opportunities provided. In this sense, public involvement is seen as 'a continuum that ranges from providing information and building awareness, to partnering in decision-making.

*(*See also the *British American Tobacco Kenya PLC case)*

107. The decisions make it clear that public participation and involvement must be reasonable, meaningful and real both

qualitatively and quantitively. The public must be given an opportunity to participate in the legislative or other processes and the body responsible must take reasonable and positive measures to facilitate engagement and participation and has the burden to demonstrate that it discharged the obligation by facilitating public participation that was reasonable, efficient and effective.

108. The respondents stated in their responses and submissions that there was need to review the existing policy to among others align it with the Constitution, 2010 and the legal framework. The policy review commenced in 2016 and was a product of a comprehensive public exercise, stakeholder and public engagement.

109. According to the respondents, stakeholders were engaged throughout the process as evidenced by letters by the Council of Governors; the letter by the Cabinet Secretary; the technical directive by the Ministry; a joint Policy consultative meeting held at Lake Naivasha Resort on 20th and 21st November 2020 and a

publication summit held from 20th April to 25th April 2022 at Pride Inn Flamingo, among others.

110. The respondents maintained that the policy was subjected to sufficient and meaningful public engagement on many occasions and places before it was eventually launched. It was the respondents' position therefore that the policy was made in a transparent and inclusive manner and adhered to constitutional requirements of public involvement and participation.

111. The respondents' position was supported by the 3rd interested party that sufficient stakeholder's engagement and participation was conducted. Stakeholders, including medical experts in Paediatrics, Obstetrics and Gynaecology; Ministry of Health technical departments, community service organizations and international partners, among others, were involved.

112. According to the 3rd interested party, the Council of Governors even sought more time to submit county views; civil society organizations were also asked to submit views to improve the

policy and the department of health and sanitation of Kisumu County also summited a memorandum on the policy. The Council of Governors called for a further meeting to include the Health Committee members of the Council of Governors and members of the Health Committees of both Houses of Parliament which was held on 28th September 2021 at Enashipai Resort in Naivasha. The two levels of government again held a joint consultative meeting on the policy at Lake Naivasha Resort on 20th and 21st November 2021.

113. The 3rd interested party pointed out that the Ministry held several consultative meetings over the policy and engaged various stakeholders between 2020 and 2022. On 31st March 2022, the Ministry invited reproductive health stakeholders and heads of civil societies involved in reproductive health to a meeting on 6th April 2022 at the Emory Hotel and shared a copy of the policy.

114. I have read the affidavits sworn on behalf of the petitioners. The petitioners admitted receiving invitations and that meetings were held. Some of the petitioners admitted to have been specifically invited and attended some of those meetings and made their contributions over the policy, though they stated that the draft policy document was not given in violation of Article 35 of the Constitution.

115. The petitioners' case in so far as public participation is concerned, can be discerned from the petition and affidavits. From the petitioners' own averments and depositions there are admissions that meetings were held to discuss the policy; they attended some of the meetings and made contributions. The petitioners even admitted that one of the meetings was to be held at Pride inn Flamingo Resort, Mombasa and Emory Hotel in Nairobi. The 1st respondent sent out invitations on 28th June 2022 but some of the petitioners stated that due to short notice, some stakeholders, including the 1st and 4th petitioners did not attend.

Those who attended indicated that the validation meeting was not participatory but a dress down from the Head of the Reproductive and Maternal Health Division. The respondents controverted the petitioners' assertions. The 3rd interested party was in particular categorical that the policy document was given out.

116. The 1st and 2nd petitioners also admitted attending some of the meetings over the policy, including one held on 6th April 2022 at Emory Hotel in Kileleshwa, Nairobi where various participants from the civil society pointed out shortcomings in the draft policy that would, in their view, be detrimental to provision of health care services to women and girls.

117. In particular, the 2nd petitioner admitted receiving an invitation on 18th April 2022 from the Ministry to attend a workshop on the policy between 25th April 2022 and 29th April 2022 at Pride Inn Flamingo Resort Mombasa. During the

workshop, participants made contributions on what they thought were shortcomings in the draft policy.

118. There is no doubt from the pleadings, depositions in the affidavits and arguments by parties, that indeed there was stakeholders' engagement and participation over the policy. Both sides admitted that meetings were convened and attended by different groups of participants, including some of the petitioners and who made contributions over the policy. The petitioners themselves admitted to taking part in some of those meetings and presented their views over the policy. The record also shows that county governments and members of Committees of Parliament were invited and attended some of the public engagement meetings.

119. In that respect, the court is not persuaded with the petitioners' contention that there was no effective public engagement or participation. Although some of the petitioners received

invitation, including on the validation of the policy, they attended some while skipped other meetings. The petitioners alleged that those who attended the validation meeting indicated that the meeting was not participatory but a dress down from the Head of the Reproductive and Maternal Health Division. This was a mere statement not attributed to any particular participant and therefore hearsay and of little evidential value.

120. The essence of public participation is to give the public and especially those interested, an opportunity to know about the issue, participate and have adequate say on it. In this respect, the Ministry's duty was to provide meaningful opportunities for stakeholders to participate in the process while taking measures to ensure stakeholders took advantage of the opportunities provided for them to be involved in that process.

121. From the pleadings, depositions, argument by parties as well as the record, there is no doubt that the petitioners were aware and were involved in the development of the policy. They

received invitations and attended some meetings but chose not to attend others. The fact that a particular person or group of persons decided not to attend particular meetings though invited, or disengaged from the process for whatever reason, would not on its own discredit or invalidate public involvement and participation over the policy.

122. It is also important to state here that it cannot be the position in law that if a particular person or group of persons, including the petitioners, did not participate in the policy development and or eventual validation, would invalidate the policy. Legislative or policy formulation process is a national exercise calling on those interested to participate in that exercise. It suffices if the body responsible notifies the public about the process, gives information on the process and facilitates an opportunity for the public and those interested to be involved, attend and participate in that process. That is what the 1st respondent did with regard to the policy.

123. In the circumstances, based on the facts in this petition, the conclusion I come to, is that there was sufficient, meaningful and effective public involvement participation over the policy. Further, the policy document was made available to stakeholders otherwise it would not have been possible for participants, including the petitioners and interested parties to pointed out what they thought were shortcomings in the policy and make recommendations for consideration if they had not seen a copy of the policy.

Violation of rights/constitution or the law

124. Having determined the issue of public participation, the next issue is whether the policy violates various rights and fundamental freedoms, the Constitution or the law. On this issue, the petitioners argued that various clauses in the policy violate reproductive rights of various groups, the Constitution and the law. The petitioners took issue with various clauses in the policy that they

considered violative of reproductive health rights as well as being inconsistent with the constitution and the law.

Children and parental consent

125. The petitioners argued that the policy violates children's right of access to reproductive health care services by requiring parental or guardian consent or consent from children officer thus, placing unreasonable hinderance in cases of emergency where a parent, guardian or children officer is not available.

126. In this respect, the petitioners took issue with Clause 3.4.8 paragraph 8 arguing that it failed to appreciate emergency situations when a child may require reproductive health care services but there is no parent, guardian or children officer to give consent. The petitioners were of the view, that requiring parental, guardian or children officer's consent under such circumstances, the policy violates children's right to access reproductive health

care services. In order to respond to this concern, it is important to discern who is a child in the context of the law.

127. Article 260 of the Constitution defines "child" to mean "*an individual who has not attained the age of eighteen years.*" The Children Act, which was enacted to give effect to Article 53 of the Constitution, reiterates the definition in the Constitution that a child means *"an individual who has not attained the age of eighteen years."* In that respect, persons under the age of 18 are children in law and are the persons the petitioners argue the policy violates their rights to access reproductive health care by requiring parental consent.

128. Article 43 (1)(a) of the Constitution confers on every person the right to the highest attainable standard of health, including reproductive health care. Similarly, section 6(1) of the Health Act provides that every person has the right to reproductive health care which includes (a) *"the right of men and women of*

reproductive age to be informed about, and to have access to reproductive health services including to safe, effective affordable and acceptable family planning services."

129. Children are persons and therefore are entitled to the highest attainable standard of health care services, including reproductive health care not only under the Constitution but also under the Health Act and Children Act. However, for children who have not attained majority age, the policy requires parental consent before they can access reproductive health care services which the petitioners have faulted as a violation of their right to heath care services.

130. Clause 3.4.8 of the policy deals with promotion of gender equity, addressing Female Genital Fistula (FGF); elimination of Female Genital Mutilation, eradication of all forms of gender-based violence and harmful reproductive practices.

131. The impugned Paragraph 8 thereof states as follows:

> *Enforce parental consent, and in the absence of both parents, consent from a guardian or the children's officer acting in the best interest of the child in the provision of RH services, with emphasis on rehabilitation of minors engaged in sexual or reproductive activities into protective safety corridors such as school re-entry, child rescue programs, or cash for transfer programmes to facilitate exit from the vicious cycle of child sexual abuse and repeat premature childbearing.* (underlining)

132. The petitioners impugned the policy on the basis that it imposes parental consent as a condition precedent for a child to access reproductive health care services even in cases of emergency. It is important to note that section 16 (1) of the Children Act provides that every child has the right to the highest attainable standard of healthcare services in accordance with Article 43 of the Constitution. However, the section states that provisions of reproductive health services to children "*shall be subject to the express consent of the parent or guardian.*"

133. It is therefore a legal requirement that provision of reproductive health care services to children be done with express consent of the parent or guardian. In the absence of a parent or guardian, the policy has added the Children Officer as another person who can give consent. The requirement of children officer must have been informed by the fact that there are circumstances when a parent or guardian may not be available yet the child needs reproductive health care services such as during an emergency.

134. Under the policy and section 16 (1) of the Children Act, consent is only required in cases where provision of reproductive health care services is required. All other health care services to children do not require parental consent, demonstrating the primacy the law places on access to health care service by children.

135. The petitioners' challenge to the policy regarding parental consent did not appreciate the fact that parental consent before providing reproductive health care services to children is a legal

rather than policy requirement. The policy merely echoes the position in law and only adds the children officer in the event the parent or guardian is not available to fill a gap thus, taking care of situations of emergency the petitioners were concerned about.

136. In that respect, requiring parental consent before a child can access reproductive health care services is in the best interest of the child. The Children Act defines "best interest of the child" to mean the principles that prime the child's right to survival, protection, participation and development above other considerations and includes the rights contemplated under Article 53(1) of the Constitution and section 8 of the Children Act.

137. In the circumstances, the petitioners' argument that the policy violates children's right of access to reproductive health care services by demanding parental consent, that of guardian or children officer before accessing reproductive health care services including during emergency situations where a parent, guardian

or children officer is not available is not correct and the policy does not contradict the Constitution or the law in that regard.

Persons above 18 years but below 21 years

138. The petitioners also argued that the policy impedes access to information by young people by precluding those above 18 years and under 21 years. In the petitioners' view, the policy uses exclusionary language against adolescent women and young girls from benefiting from reproductive health care services.

139. According to the petitioners, the policy engenders discrimination against young women below 21 years with regard to reproductive healthcare interventions on grounds that they have not attained full cognitive competence on sexuality and reproduction matters. The petitioners contended that by making a blanket intervention, the policy/Ministry failed to give regard to both facts and evidence on teenage pregnancies and HIV and

AIDS infections thereby contradicting laws and other policies. The 1st and 2nd interested parties supported the petitoners' position.

140. I have considered the arguments by parties on this issue and perused the policy. There is no specific clause in the policy that prohibits women above 18 but below 21 years from accessing reproductive health care services or information. Clause 2.3.3 of the policy is a general statement on unmet family planning needs. The clause states that Kenya Demographic Health Survey, 2014 reported a dramatic increase in use of modern contraceptives among currently married women of between 15-49 years during the 5 years, among currently married women with a minimal rural-urban variation in current modern contraceptive use by married women. The Clause points out, however, that women in the poorest wealth environment had much lower contraceptive use.

141. Clause 2,3.4 on adolescent/youth reproductive health, states generally, that according to a survey, adolescent health constitutes an ongoing challenge; that childbearing begins early in Kenya with almost one-quarter of women having given birth by age 18 and nearly half had started childbearing by age 20. Age specific fertility rate for 15-19-year-old has decreased. However, the proportion of adolescent women age 15-19 already mothers or pregnant with their first child at the time of the survey remained unchanged from the previously reported 18% in 2008/9.

142. The Clause points out that "A recurring challenge" has been the failure to develop a dignified transition from childhood to adolescent and onto young adulthood, including parenting and guardian support. According to the clause, majority of reproductive health challenges facing adolescents and young women are related to this gap in programming. A significant proportion of young people continue to have incorrect perception or invisibility of their risks to early sexual debut; acquiring sexually

transmitted infections, HIV, alcohol, drug and substance abuse as well as negative impact of social media.

143. Accordingly, this suggests a need to promote programmes that will reverse this pattern over time, including support during the transition of cognitive maturity and limited decision-making capacity as minors. There is also need to clarify the age of consent for the various reproductive health interventions in view of the varied provisions in different guidelines and lack of explicit legal pronouncements on the issue.

144. The Clause recommends "Structural prevention interventions such as protection from pornography, keeping children and young people in school or gainful engagement, free sanitary towel programs for girls, cash transfer social protection programs, physical protection corridors–after school transit programs, safe houses and justice for minors who are SGBV survivors.

145. The clause does not state that this age group (18-20) should not access reproductive health care services. It cannot also be assumed to be the case as doing so, would be in violation of the Constitution and the law. One must bear in mind section 5 of the Health Act which providers that every person has a right to the highest attainable standard of heath which *"shall include access for provision of promotive, preventive, curative, palliative and rehabilitative services."*

146. Further, section 6(1)(a) of the Health Act provides in plain language that every person has the right to reproductive health which includes- *"the right of men and women of reproductive age to be informed about, and to have access to reproductive health services including to safe, effective and affordable and acceptable family planning services.* Section 7(1) further provides that every person has the right to emergency medical treatment.

147. It is also important to note that just like Article 43(1) (a) of the Constitution, sections 5; 6(1)(a) and 7(1) of the Health Act use the words "every person" which means every individual has the right to not only reproductive health care but also emergency medical treatment regardless of the type of the emergency as long as the person requires immediate and urgent medical attention, save in cases requiring parental consent under section 16 (1) of the Children Act.

148. Section 6(1) (a) of the Health Act again makes it plain that both men and women "*of reproductive age"* have the right to be informed about, and have access to reproductive health care services, including safe, effective, affordable and acceptable family planning services. The section does not place any conditions as long as one is of reproductive age. This position is also captured at Clause 3.4. 1 of the policy which states that: "*All women of reproductive age shall have adequate access to quality reproductive health care that is respectful and provides a positive care experience for them and their families*." In this regard, both

the policy and the law safely cover those in the age bracket of 18 to 21 years. I therefore find no fault with the policy in that regard.

Termination of pregnancy

149. The petitioners again faulted the policy with regard to termination of pregnancy. According to the petitioners, the policy introduces a requirement of the life of the child as a consideration before termination pregnancy yet the Constitution only recognises the life and health of the mother as a condition precedent to terminating pregnancy. This view was supported by the 1st and 2nd interested parties. The respondents and 3rd interested party supported the policy, arguing that the unborn child has a right to highest attainable standard of health and the right to life which should also be taken into account.

150. Clause 2.3.2 recognises the problem of teenage pregnancies in the country, noting that the rate of teenage pregnancy has remained unchanged for decades and is a concern to the nation. The clause identifies multiple players and points of intersection in teenage pregnancy as well as the social and cultural contributions to the problem. The clause points out that the intention of the policy is to prioritize scientific effective interventions to reduce teenage pregnancy and motherhood in a multi-sectoral collaborative and enforcement approach.

151. On termination of pregnancy, Clause 3.4.1 paragraph 12 states:

> *Termination of pregnancy shall be performed in an environment meeting the minimum medical standards and guided by the opinion of a trained health professional with the proficiency to ensure both the mother and her unborn child receive the highest attainable standard of healthcare*

152. According to the petitioners, paragraph 12 is unconstitutional to the extent that it introduces the aspect of the health of the unborn child which is not a requirement under the Constitution.

153. Article 26 of the Constitution provides:

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

154. The Constitution expressly prohibits abortion but permits it under certain conditions. The permissible conditions are: if, in the

opinion of a trained heath professional, the mother requires an emergency treatment or if the health or life of the mother is in danger and in cases where a written law allows termination of pregnancy.

155. Article 26(4) of the Constitution places the health and life of the mother above everything else when a trained health professional is considering whether or not to terminate pregnancy. This is so, where in the opinion of the trained health professional, the mother requires emergency treatment and the effect of such treatment would lead to termination of pregnancy. The trained health professional has to determine if it would be for the benefit of the life and health of the mother that the pregnancy be terminated.

156. Abortion or termination of pregnancy means an early ending of pregnancy with the aim of stopping growth of the foetus to full term. That is; premature ending of pregnancy before its term. Termination of pregnancy has to be performed by a trained

health professional through a safe procedure that stops the growth of the pregnancy thereby saving the life or health of the mother. In that respect, the constitutional dictum is that abortion be performed only if in the view of the trained health professional the mother requires emergency treatment or her health or life will be in grave danger unless the pregnancy is terminated.

157. The impugned paragraph 12 of Clause 3.4.1 of the policy states that *Termination of pregnancy shall be performed in an environment meeting the minimum medical standards and guided by the opinion of a trained health professional with the proficiency to "ensure both the mother and her unborn child receive the highest attainable standard of healthcare."*

158. Termination of pregnancy or abortion means ending the pregnancy if in the opinion of a trained health professional the mother requires emergency treatment or the mother's health or life is in danger and comes after the trained health professional has examined the mother and determined that the mother needs

emergency treatment or her health or life is in danger and makes a decision to terminate the pregnancy. At that point it is the health or life of the mother that is being saved and therefore ensuring that both the mother and her unborn child receive the highest attainable standard of healthcare would not be in issue.

159. The Constitution having provided a right to abortion where in the opinion of a trained health professional there is need for emergency treatment, or the health or life of the mother is in danger, the requirement in the policy to ensure ensure both the mother and her unborn child receive the highest attainable standard of healthcare negates the requirement in the Constitution. The Constitution having provided clearly for the permissible circumstances under which abortion would be allowed, the policy cannot second guess the Constitution by introducing new conditions or expanding the permissible grounds to include ensuring the highest standard of health of the mother and the unborn child which falls a foul the Constitution.

160. I agree with the petitioners that by introducing the health of the unborn child, the policy contradicts the Constitution and therefore paragraph 12 of clause 3.4.1of the policy is inconsistent with the Constitution to the extent that it introduces the highest attainable standard of health of the unborn child during the abortion permitted by the Constitution.

Family planning and HIV and AIDS

161. The petitioners again attacked the policy on grounds that it makes HIV and AIDS testing compulsory in violation of other law and policies, including section 13 of the HIV and AIDS Preventioin and Control Act and section 34 of the East African Community HIV and AIDS Prevention and Management Act. The respondent argued that the policy does not contradict the law or other policies.

162. Clause 3.4.4 of the policy deals with the need for reduction of HIV and AIDS burden and accelerating reversal of mother to child

transmission of HIV. Paragraph 1 requires integration of HIV and AIDS control in reproductive health while under paragraph 2, the policy is to *"Ensure all pregnant women and their families are tested for HIV and those HIV infected access quality HIV care and treatment including ARVs."*

163. Section 13 of the HIV and AIDS Prevention and Control Act provides that no person should be compelled to under go an HIV test as a precondition to, among others, the provision of health care. The section prohibits forced HIV testing as a basis for receiving health care services. What the section prohibits is forced testing. However, the policy requirement for testing is for purposes of preventing mother to child transmission.

164. Section 34 of the East African Community HIV and AIDS Prevention and Management Act requires governments to ensure that women and girls have access to adequate and gender sensitive HIV related information. However, it is also important to bear in mind section 16 of the Act which requires that a testing

facility or person carrying out an HIV test should in all cases provide a pre-test and post-test counselling to a person undergoing an HIV test, or in the case of a child or person living with disability. consent of that person. Section 17 of the Act provides for the minimum information to be provides during the pre-test counselling, including the nature and purpose of HIV and AIDS test and the clinical and preventive benefits of testing, among others.

165. The aim of Clause 3.4.4. paragraph 2 of the policy is to ensure there is prevention of mother to child HIV and AIDS transmission. This can only be achieved if mothers are tested. However, before one is tested reproductive health care providers have to comply with the law on pre-test and post-test counselling and only proceed to test after obtaining consent of the person to be tested. Without testing, there would be little success in preventing mother to child HIV and AIDS transmission or even provide treatment to those already infected. The requirement for testing does not, in my respectful view, violate the right of those seeking reproductive

health care services in relation to family planning services or the law.

Discrimination

166. The petitioners again argued that the policy uses discriminatory language so that family planning is for couples only thereby excluding the unmarried women. The policy captures family planning at Clause 3.4.2 which states in the preamble that Family planning is a premier investment in reducing reproductive health morbidity and mortality. The clause observes that "*A couple"* that has achieved their desired family size is not only more likely to be a stable family unit but is also likely to be a better empowered socio-economic pillar for the nation.

167. The clause emphasises that family planning is a national security issue and therefore every effort will be made to free the country from external dependency and undue influence on this

crucial element of a nation's sovereignty. The clause goes on to state what should be done.

168. Clause 3.4.2 paragraph 5 then states that the policy is to "*Ensure the safety and positive care experience for women and men accessing FP interventions."* Clause 3.4.2 Par 6 provides for Mainstreaming HIV and STI prevention in every FP "*intervention"* at all levels of healthcare and for all clients. Para 5 is in relation to those men and women (clients) who voluntarily go to seek family planning interventions, while par 6 is still for those who go for family planning services so that they are informed how to prevent HIV and STI during their visits. I do not find any contradiction and the fact that the paragraphs use the word "couple" does not exclude unmarried women.

Infertility treatment

169. The petitioners yet again raised concerns with regard to Clause 3.4.11 par 5 and 6. Clause 3.4.11 is on reduction of infertility and increase accessibility to effective management of infertile

individuals and couples. It is important to look at the whole clause to ascertain the real meaning and effect of the impugned clause 3.4.11.

170. Paragraph 1 is on improving access to quality infertility services at all levels; Paragraph 2 is on promotion of community awareness on infertility, especially among males; paragraph 3 seeks to encourage research on all aspects of infertility; paragraph 4 seeks recognition of the rising burden of Primary and Secondary infertility and integration of fertility care into STI prevention and treatment.

171. Paragraph 5 then states:

> *Finance establishment, certification and regulation of fertility care centres in the country and fully finance at least one cycle of assisted fertility treatment (ART) per needy desirous couple through The National Treasury and The National Insurance Fund.*

172. Paragraph 6 again states:

Support couples of the opposite sex establishing or furthering a family, who for gynaecological reasons it has been established cannot conceive and sire normally, commission as parents a willing surrogate mother to bear them a child through assisted reproductive technology, without monetary inducement except for the costs agreed to cover the entire process from embryo transfer to birth of the baby or otherwise, and as guided by the applicable laws and policies on surrogacy. The Cabinet Secretary for Health shall establish specific guidelines to bring into effect this policy direction.

The question that arises is whether paragraphs 5 and 6 of clause 3.4.11 of the policy are discriminatory.

173. Article 27 (1) of the Constitution provides that every person is equal before the law and has the right to equal protection and equal benefit of the law, while Sub Article (3) states that Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres. Sub Article (4) provides that the State shall not discriminate directly or indirectly against any person on any

ground, including marital status, health status and age, among others. In that respect, Article 27 prohibits all forms of discrimination.

174. In *peter K Waweru v attorney General* [2006] eKLR, the court defined discrimination to mean:

> *[A]ffording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, tribe, place of origin or residence or other local connection, political opinions, colour, creed or sex whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages which are not accorded to persons of another such description.*

175. In *Jacqueline Okeyo Manani & 5 others v Attorney General & another* [2018] eKLR, the court stated:

> *[28]. [D]iscrimination...is any distinction, exclusion or preference made on the basis of differences to persons or group of persons based on such considerations as race, colour, sex, religious beliefs political persuasion or any such attributes*

that has real or potential effect of nullifying or impairing equality of opportunity or treatment between two persons or groups.

(See also *Nyarangi & 3 others v Attorney General* [2008] eKLR).

Discrimination is according different treatment to persons or group of persons belonging to the same category.

176. Paragraph 5 of clause 3.4.11 acknowledges the need to put in place mechanisms including availing financial resources, certification and regulation of fertility care centres in the country and cater for at least one cycle of assisted fertility treatment per needy desirous *"couple"* through The National Treasury and The National Insurance Fund (now repealed).

177. Under Paragraph 6, the policy seeks to support *"couples of the opposite sex"* seeking to establish or further a family, who for gynaecological reasons it has been established cannot conceive and sire normally and commission as parents a willing surrogate mother to bear them a child through assisted reproductive

technology. In doing so, the policy (para 6) discourages monetary inducement except the costs agreed to cover the entire process from embryo transfer to birth of the baby or as guided by the applicable laws and policies on surrogacy. The Cabinet Secretary for Health is required to establish specific guidelines to bring into effect this policy direction.

178. Paragraphs 5 and 6 do not expressly prohibit any person from seeking assisted fertility treatment. The paragraphs are clear that *"couples of the opposite sex"* seeking to establish or further a family but who, for gynaecological reasons cannot conceive and sire normally can access assisted fertility treatment. Even though the two paragraphs use the word "couple", the word does not necessarily mean married people. It could also mean those engaged, or otherwise in a relationship. The policy expounds that those seeking assisted fertility treatment be of the *"opposite sex"* which is in harmony with Article 45(5) of the Constitution. The paragraphs do not also require those seeking fertility treatment

to provide evidence of marriage and therefore the alleged discrimination has not bee demonstrated.

179. The petitioners argued that the policy did not take into account the fact that there may be other reasons other for not conceiving other than gynaecological reasons without stating these reasons. In the circumstances, I do not agree that paragraphs 5 and 6 in clause 3. 4. 11 are discriminatory or have any constitutional or legal deficiencies.

Cancer screening

180. The petitioners assaulted Clause 3.4.5 regarding cervical cancer screening on the grounds that despite evidence of sexual debut below the age of 19 based on the rate of adolescent pregnancies and documented cases of cervical cancer in women as young as 22 years old, the policy recommends cervical cancer screening from age 25. In the petitioners' view, there is need for the policy to promote patient-centred individualized screening for younger

women with a higher risk profile otherwise the policy presents an element of discrimination regarding screening of cancers.

181. Clause 3.4.5 is on morbidity and mortality associated with common cancers of reproductive organs in men and women. Paragraph 1 advocates for increase in availability of high-quality services for the prevention, early detection and management of cancers of reproductive organs, as appropriate at all levels.

182. Paragraph 2 states that recognizing that cervical cancer is a leading cause of death among women, and is almost entirely preventable if detected early, all levels of government should appropriate resources to guarantee that each sexually active WRA aged 25 years or more is offered, or referred for, a free cervical cancer screening test linked to accredited pathology referral and reporting system, and specialist care as may be needed. Paragraph 3 is on enhancing programmes that support creation of awareness of and sensitize the community on cancers

of reproductive organs, including the voluntary national free HPV vaccination program. Paragraph 4 speaks to promoting research on all aspects of cancers of the reproductive organs; paragraph 5 addresses promoting the collection and utilization of data on cancers of reproductive organs in both men and women of all ages while paragraph 6 is on promoting screening for prostate cancer for men of 40 years and above at all levels.

183. Clause 3.4.5 recognises the dangers of cancers of the reproductive organs and provides for screening of women aged 25 years and above for cervical cancer and men of 40 years and above for prostrate cancer. This is a general policy statement but people can get screening at any time. Paragraph 5 further advocates for promotion of collection and utilization of data on cancers of reproductive organs in both men and women of all ages which is clear that all ages are taken care of and this cannot be said to encourage discrimination. The petitioners seemed to be overly concerned about women when the policy talks of women aged 25 years and above ignoring the fact that the same clause

talks of men aged 40 and above. For my part, I see no violation or discrimination since the policy does not prohibit cervical cancer screening for those below 25 years.

Intersex persons

184. The petitioners again assailed Clause 3.4.12 paragraphs 1, 3 and 5 on intersex persons. The Clause acknowledges intersex as a disabling developmental state and provides that persons born intersex are entitled to the highest standard of reproductive health.

185. Paragraph 1 appreciates that sex definition in Kenya is retained as Female or Male, but with recognition that intersex is a disabling developmental state presenting ambiguous genitalia at birth. The paragraph also notes that intersex can manifest variously from true intersex to normal variants of either the Female or the Male sex marker, which is highly medically and socially disruptive

to the individual and the family. The paragraph emphasizes that the policy recognizes and protects constitutional rights of persons born intersex and outlaws discrimination and inhumane treatment targeting such persons, including forced premature medical sex reassignment. The paragraph points out that the policy lays the groundwork for resourcing a national avenue for *"scientifically and professionally guided intersex transition to a definitive sex identity."*

186. Paragraph 3 notes that medical procedures on persons born intersex are highly specialized, multidisciplinary, medically complex and carry significant life-threatening risks. The benefiting person often needs lifelong care and support even after the corrective medical procedures. For that reason, caution before, during and after surgery must be employed and these procedures should be deferred to an opportune time after puberty and after the persons "*attain the age of majority when the person born intersex is counselled, grants informed consent"* and the person is facilitated to present before a professional body dedicated, and

resourced by the state to facilitate medical–and social transition to the actual sex. Paragraph 5, on the other hand, requires that the birth of a child with ambiguous genitalia be reported or notified to a government health facility.

187. The petitioners argued that paragraph 5 of Clause 3.4.12 introduces bureaucracy into the registration of children born with ambiguous genitalia by providing that these births be reported or notified to a government health facility but does not provide a solution to the systemic discrimination in registration of intersex persons at birth and creates further differentiation without justification.

188. The petitioners, apart from alleging stigmatization and bureaucracy in registering intersex persons, did not demonstrate how paragraphs 1; 3 and 5 either violate the Constitution or rights of the persons born intersex. Paragraph 1 emphasises on the recognition and protection of constitutional rights of persons born intersex and outlaws discrimination and inhumane treatment

targeting such persons, including forced premature medical sex reassignment. The paragraph points out that the aim of the policy is to lay the groundwork for resourcing a national avenue for scientific and professional guided intersex transition to a definitive sex identity for the interest of the intersex persons.

189. Paragraph 3 again appreciates the complexity and highly specialised nature of the medical procedures required by persons born intersex to correct their actual sex thus, calling for caution before, during and after surgery. The policy recommends that such procedures be deferred possibly until after puberty and upon the person attaining the age of majority so that such person is counselled; grants informed consent and is facilitated to go before a professional body dedicated, and resourced to facilitate medical–and social transition to the actual sex. Paragraph 5 on its part, requires that the birth of a child with ambiguous genitalia be reported or notified to a government health facility.

190. The requirements in Cluse 3.4.12 paragraphs 1, 3 and 5 are for the benefit of persons born intersex as opposed to violating their rights and fundamental freedoms or even the Constitution or the law. Notification of cases of persons born intersex will help in data collation so that the country has a record of the number of persons born intersex just like there is a record of those born Female and Male. In the circumstances the court is unable to agree with the petitioner regarding any violations in so far and intersex persons are concerned.

Freedom of Research

191. The petitioners again argued that the policy limits freedom of scientific research in violation of sections 6 and 7 of the Science, Technology and Innovation Act and the role of the National Commission on Science, Technology and Innovation. In this respect, the petitioners impugned Clause 3.4.13 paragraph 2 of the policy.

192. Clause 3.4.13 is on strengthening research development and innovation and use of research evidence for reproductive health intervention. The impugned paragraph 2 states that "*The Director-General of Health shall be the custodian of Reproductive Health research conducted in the Country.*"

193. The office of the Director General of Health is established under section 16 of the Health Act which also provides for the appointment and qualifications while section 17 delineates functions of that office. One of the functions under section 17 (f) is to *"promote and facilitate research investigations in connection with the prevention or treatment of human deceases"* and (g) *"prepare and publish reports and statistical or other information relative to public health."*

194. Section 93 of the Act establishes the National Health Research Committee whose composition is provided for under section 94 and its mandate under section 96. Section 96(1) states that the Committee shall make recommendations on the development on

national research for health policy and on the various priorities to be accorded in the area of research for health in light of current knowledge and needs, recognised priorities and economic resources.

195. Pursuant section 96(3) (c), the committee is to, among others, develop and advise the Cabinet Secretary on the application and implementation of an integrated national policy and strategy for health research, while under section 96(4), the Committee is to execute it functions through the head of the directorate of the ministry of health responsible for research and development who shall be its secretary.

196. Section 9 7(1) is material and provides that:

> *The Kenya Medical Research Institute established under the Science and Technology and Innovation Act shall review its programmes to optimally attune to the health interests of the population and the overall programme of health research.*

197. On the other hand, section 3 of Science, Technology and Innovation Act establishes The National Commission for Science, Technology and Innovation whose objective under section 4 is to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto. The functions of the Commission are provided for under section 6 while section 7 is on the Guiding principles.

198. A Keen reading of sections 6 and 7 of the Science, Technology and Innovation Act alongside the Health Act and, in particular, section 17 on the functions of the Director General of Health, does not reveal any conflict in relation to the functions of that office *visa vis* the functions of the National Commission for Science, Technology and Innovation. Section 97(1) of the Health Act recognizes the existence Kenya Medical Research Institute established under the Science, Technology and Innovation Act and requires Kenya Medical Research Institute to review its programmes to optimally align them with the health interests of

the people and the overall programme of health research. In the circumstances, the fact that clause 3.4.13.2 of the policy designates the Director General of Health as the custodian of reproductive health research conducted in the country, is grounded on sections 16 and 17 of the Health Act and is not inconsistent with or in contravention of sections 6 and 7 of Science, Technology and Innovation Act or the mandate of the Commission established under section 3 of that Act since the Director General of Public Health is the custodian of research on reproductive health while the Commission is to regulate and ensure quality in the science, technology and innovation sector and advise the Government in matters related thereto; that is the commission is in charge of research generally.

Interference with Research

199. Finally, the petitioners impugned Clauses 3.4.13 and 4.2.3.8 paragraph 5 arguing that they interferes or inhibits research in the country and ignore the role county governments play in

promoting diversity by providing for mainstreaming of reproductive health research.

200. Clause 3. 4.13 is on strengthening research and innovation and use of research evidence for reproductive health. Paragraph 4 is on strengthening County Health Management Teams capacity to implement evidence-based reproductive health programs as articulated in the policy and provide contextual leadership. Paragraph 5 requires national and county governments to enhance prudent management of existing reproductive health resources from the exchequer and collaborate with partners to augment these resources, while paragraph 6 is on Mapping National and County Reproductive Health partners to harmonize their work with the support they offer in Reproductive Health Policy implementation.

201. Clause 3.4.13 does not exclude or ignore the role of county governments in promoting diversity in reproductive health research and the petitioners did not point out how this is the case.

A reading of the clause does not show any likely interference with research as the petitioners argued.

202. Clause 4 which is Chapter 4 of the policy is on the policy implementation framework. Clause 4.2.3.8 is on Research and Development. Paragraph 5 thereof advocates for vetting of reproductive health research in the country and prioritises research that aligns with the pressing reproductive health concerns for the Ministry of Health and the country.

203. It is useful to note, that under Clause 4.2.3.8, the policy appreciates that currently research on health, including reproductive health, is not appropriately coordinated which has led to unwarranted duplication and limiting optimal use of resources and findings. The clause notes that research funding has remained low and the sector has continued to rely on donors and partners for funding. Translation of research findings into sustainable improvements in health outcomes has remained an obstacle to improving the quality of care.

204. The clause further notes that research is a critical pillar of evidence generation and quality assurance of reproductive health interventions thus, no intervention or program in reproductive health should be implemented unless it has been shown to be effective in improving the target sexual reproductive health outcome or preventing the target adverse reproductive health outcome.

205. The clause further observes that in the absence of effectiveness evaluation of the intended intervention or program in Kenya, such an intervention or program should be deemed experimental and should have an embedded elaborate effectiveness evaluation plan. The clause states that the contextual effectiveness evaluation plan should be shared at the beginning of the intervention, include a mid-term effectiveness evaluation, and an independent end-term effectiveness evaluation policy brief. These reports should be submitted to the Director General for Health without exception.

206. In this regard the focus should be;

1. Mainstreaming of reproductive health research and capacity building at national and county levels
2. Enhanced investment in reproductive health research and evidence generation
3. Operationalize the Data protection Act provisions in reproductive health
4. Strengthened research links with other state actors, academic institutions and SAGAs in the RH
5. "*Vet RH research in the country and prioritise research that aligns with the pressing RH concerns for the MOH and the country.*"

207. Clause 4.2.3.8 paragraph 5 does not in any way inhibit or interfere with research. Rather, under the paragraph, the policy intends to coordinate, synchronise and direct research in reproductive health for the benefit of the country's population taking into account the limited financing. This will also make research on reproductive health relevant and meaningful. I see not fault in Clause 4.2.3.8.5 in that regard.

208. The petitioners were also of the view, that Clauses 3.4. 13 and 4.2.3.8 at paragraph 5 shuns the role county governments play in promoting diversity by providing for the mainstreaming of reproductive health research. However, the petitioners did not demonstrate this to be the case.

Conclusion

209. Having considered the pleadings, arguments by parties, decisions relied on, the policy *visa vis* the Constitution and the law, the conclusion this court comes to, is that there was meaningful and effective public participation in formulating and developing the National Reproductive Health Policy. Stakeholders were involved and gave views that informed the policy formulation and development.

210. The National Reproductive Health Policy does not violate the Constitution, the law or rights and fundamental freedoms, except the reference to the health of the unborn child at clause 3.4.1

paragraph 12 which is inconsistent with article 26(4) of the Constitution and the petition succeeds to that limited extent.

211. Consequently, the court makes the following declaration and order.

1. A declaration is hereby issued that paragraph 12 of clause 3.4.1 of the National Reproductive Health Policy, 2022-2032 is unconstitutional to the extent only that it introduces the highest standard of health of both the mother and the unborn child as a consideration in terminating pregnancy which is inconsistent with article 26(4) of the Constitution.
2. This being a public interest litigation, each party shall bear their own cost.

Dated and delivered at Nairobi this 2nd Day of October 2025

E C MWITA

JUDGE