A University of Sussex PhD thesis

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Declaration

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Sign:…………………………

MaryFrances Apiyo Lukera

Date:
Acknowledgements

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Dedicated to the memory of my beloved grandmother Willimina Adionyi Lukera and to the sex workers who shared their stories.
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<td>African Charter</td>
<td>African Charter on Human and Peoples’ Rights</td>
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<td>African Commission</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>APNSW</td>
<td>Asia-Pacific Network of Sex Workers</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>AU</td>
<td>African Union</td>
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<td>AWD</td>
<td>Africa Women’s Decade</td>
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<td>AWID</td>
<td>Association for Women’s Rights in Development</td>
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<td>BCLR</td>
<td>Butterworths Constitutional Law Reports (South Africa)</td>
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<td>BHESP</td>
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<td>CAT</td>
<td>Convention Against Torture</td>
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<tr>
<td>Cap</td>
<td>Chapter</td>
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<tr>
<td>CC</td>
<td>Constitutional Court</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CEDAW</td>
<td>Committee on Elimination of Discrimination against Women</td>
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<tr>
<td>CERD</td>
<td>Convention on the Elimination of All Forms of Racial Discrimination</td>
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<tr>
<td>CESCR</td>
<td>Committee on Economic, Social and Cultural Rights</td>
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<td>COHRE</td>
<td>Centre on Housing Rights and Eviction</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<tr>
<td>CREAW</td>
<td>Centre for Rights Education and Awareness</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>CRR</td>
<td>Centre for Reproductive Rights</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>CSW</td>
<td>Commission on the Status of Women</td>
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<td>DEVAW</td>
<td>United Nations Declaration on the Elimination of Violence against Women</td>
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<tr>
<td>EACHRights</td>
<td>The East African Centre for Human Rights</td>
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<td>Abbreviation</td>
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<tr>
<td>ECHR</td>
<td>European Convention of Human Rights</td>
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<td>ECOSOC</td>
<td>United Nations Economic and Social Council</td>
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<td>ECOWAS</td>
<td>Economic Community of West African States</td>
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<tr>
<td>eKLR</td>
<td>Electronic Kenya Law Report</td>
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<tr>
<td>FBO</td>
<td>Faith Based Organisation</td>
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<td>FEMNET</td>
<td>African Women’s Development and Communication Network</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>Family Health Options Kenya</td>
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<td>Federation of Women Lawyers Kenya</td>
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<td>GEWE</td>
<td>Grassroots Approach to Gender Equality and Women’s Empowerment</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<td>HC</td>
<td>High Court</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRBA</td>
<td>Human Rights-Based Approach</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>International Convention on the Elimination of All Forms of Racial Discrimination</td>
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<td>ICESCR</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>KASH</td>
<td>Keeping Alive Societies Hope</td>
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<td>KNCHR</td>
<td>Kenya National Commission on Human Rights</td>
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<td>LSK</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MCA</td>
<td>Member of the County Assembly</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>MYWO</td>
<td>Maendeleo Ya Wanawake Organisation</td>
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<td>NGEC</td>
<td>National Gender and Equality Commission</td>
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<td>NGOs</td>
<td>Non-Governmental Organisations</td>
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<tr>
<td>OAU</td>
<td>Organisation of African Unity</td>
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<td>OHCHR</td>
<td>Office of the United Nations High Commissioner for Human Rights</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>RBA</td>
<td>Rights Based Approach</td>
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<td>Reproductive Health</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>SA</td>
<td>South Africa</td>
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<td>Supreme Court</td>
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<td>Sexual and Reproductive Health Rights</td>
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<td>SOA</td>
<td>Sexual Offences Act</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWOP</td>
<td>Sex Workers Outreach Programme</td>
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<td>TAC</td>
<td>Treatment Action Campaign</td>
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<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<td>TOP</td>
<td>Termination of Pregnancy</td>
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<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>United Nations</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNIFEM</td>
<td>United Nations Fund for Women</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VSFG</td>
<td>Very Small Focus Group</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Abstract

The right to the highest attainable standard of health, including sexual and reproductive health care, is a fundamental human right guaranteed in international human rights law. Enforcement of sexual and reproductive health rights engage the right to information, the right to life, the right to privacy, the right to health, the right to education and to non-discrimination. However, enjoyment of sexual and reproductive health rights remains weak in Africa and other parts of the world. Women in Africa particularly female sex workers face a myriad of challenges that have severe impact on their lives, even, where rights to sexual and reproductive health have been incorporated in their countries’ Constitutions. Currently, while research in Kenya has focused on sex workers, it has been limited to their criminalisation. This thesis contributes to the body of research on sexual and reproductive health rights in the African continent. The thesis focuses on the potential of rights-based laws and policies to advance sex workers’ health leading to their greater empowerment.

The thesis examines whether the adoption of a human rights approach can guarantee sexual and reproductive health of sex workers specifically in Kenya. It employs a socio-legal and empirical research method to conduct focus group and individual interviews with sex workers and professionals working directly and indirectly with them, including the police and the Division of Reproductive Health in the Ministry of Health in Kenya. The research uses transnational feminist legal theory to analyse the experiences of sex workers in the global south and to articulate the significance of international human rights law to this field of inquiry. The thesis identifies the legal and policy barriers that impede sex workers’ enjoyment of sexual and reproductive health rights. The feminist research method illuminates the voices of sex workers to show the difference between what is framed in international human rights instruments, national laws and policies, and the reality of practice in Kenya. To address this gap, the thesis suggests ways in which rights-based laws and policies can be meaningfully utilised to advance women’s sexual and reproductive health rights and to alleviate inequalities and discriminatory practices in the provision of dignified health care especially to the sex workers.
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*Beatrice Wanjiku and Another v Attorney General & Another* [2012] eKLR HC Petition No 190 2011 (Nairobi, Kenya)

*Dorothy Chioma Njemanze and 3 Others v Federal Republic of Nigeria* [2017] Suit No ECW/CCJ/APP/17/14; ECW/CCJ/JUD/08/17 (ECOWAS Court, Abuja, Nigeria)


*Federation of Women Lawyers (FIDA Kenya) and 3 others v Attorney General and 2 others* [2016] eKLR HC Petition No 266 of 2015 (Nairobi, Kenya)

*Georgina Ahamefule v Imperial Medical Centre and Dr Alex Molokwu* Suit No ID/1627/2000 (Nigeria)

*Isaac Ngugi v Nairobi Hospital and 3 Others* [2013] eKLR HC Petition No 407 of 2012 (Nairobi, Kenya)

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*Lucy Nyambura and Another v Town Clerk, Municipal Council of Mombasa and 2 Others* [2011] eKLR HC Petition No 286 of 2009 (Mombasa, Kenya)

*M A & Another v Honourable Attorney General and 4 others* [2016] eKLR HC Petition No 562 of 2012 (Nairobi, Kenya)

*Mathew Okwanda v Minister of Health and Medical Services and Others (Okwanda)* [2013] eKLR HC Petition No 94 of 2012 (Nairobi, Kenya)

*Minister of Health v Treatment Action Campaign (TAC)* [2002] 5 SA 721 (Constitutional Court, South Africa)


*Nathan Muwangi Shimwenyi v Kenyatta National Hospital and Others* [2012] eKLR HC Petition No 282 of 2012 (Nairobi, Kenya)

*P.A.O. and 2 Others v Attorney General* [2012] eKLR HC Petition No 409 of 2009 (Nairobi, Kenya)
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The Government of RSA and Others v Grootboom and Others [2000] 11 BCLR 1169 (Constitutional Court, South Africa)
Chapter One: Introduction

Where, after all, do universal human rights begin? In small place, close to home – so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person: the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman, and the child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere.\(^1\)

_I have my rights as a sex worker. No one has the right to beat me ... the law is there._\(^2\)

1.0 Introduction

The right to the highest attainable standard of health, including sexual and reproductive health, is a fundamental human right guaranteed in international human rights law.\(^3\) Human rights are indivisible, interdependent and interrelated, and sexual and reproductive health rights are essential components of human rights.\(^4\) The enforcement of sexual and reproductive health rights also engages a right to information, a right to life, a right to dignity, a right to privacy, a right to education and a right to non-discrimination.\(^5\) Violating the right to sexual and reproductive health may impair the enjoyment of other human rights and vice versa.\(^6\) Kenya, the country which is the subject of this thesis, is a State Party to numerous international and regional human

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\(^1\) Eleanor Roosevelt in her 1958 speech called ‘Where Do Human Rights Begin?’ quoted in Amnesty
\(^2\) Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
rights instruments. State Parties to international and regional human rights treaties have obligations to respect, protect and fulfil women’s sexual and reproductive health rights in their respective countries, and their inaction must be seriously challenged. For women to enjoy their sexual and reproductive health rights in Africa, barriers must be broken down. States need to be held to account. A claim for sexual and reproductive health as a human right puts the primary responsibility on the State, but, also non-state actors such as the donor community, intergovernmental organisations, international NGOs and transnational corporations whose actions bear upon the enjoyment of the right to the sexual and reproductive health in many countries, in the global south, to deliver this right.

Taking a socio-legal approach, this thesis critically examines whether the adoption of a Human Rights-Based Approach (HRBA) can guarantee the sexual and reproductive

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12 See A Bradshaw, ‘Sense and Sensibility: Debates and Developments in Socio-Legal Research Methods’ in PA Thomas (ed), Socio-Legal Studies (Dartmouth 1997) 99 states that: ‘First, socio-legal research considers the law and the process of law (law-making, legal procedure) beyond legal texts - i.e the socio-politico-economic considerations that surround and inform enactment of laws the operation of procedure, and the results of the passage and enforcement of laws. Second, in studying the context and result of law, socio-legal research moves beyond academic, the judicial and the legislative office, chamber, library and committee room to gather data wherever appropriate to the problem’; See also D Watkins and M Burton, Research Methods in Law (Ebook, Taylor and Francis 2013); R Banakar, ‘Having One’s Cake and Eating It: The Paradox of Contextualisation in Socio-Legal Research’ (2011) 7:4 International Journal of Law in Context 487.
health of sex workers in Kenya. Despite criticisms, Human Rights Based Approaches (HRBAs) are viewed as empowering since they stem from the 1948 Universal Declaration of Human Rights (UDHR) and affirm that women have a justifiable entitlement, inherent in their human dignity and worth, to basic services such as health. In an African context, as a Kenyan and an African feminist, I argue that it is appropriate to utilise an HRBA. The study is constructed around three key elements. First, it advances a theoretical framework which uses feminist legal theory to argue for an HRBA to sexual and reproductive health. Secondly, the research is situated within a doctrinal legal framework. The thesis conducts a critical analysis of the law at international, regional and national levels, and advocates protection of the sexual and reproductive health rights of sex workers in Kenya. Finally, the thesis comprises an evaluation of original data gathered from fieldwork in Kenya.

The thesis contributes to the body of research on sexual and reproductive health rights on the African continent. It focuses on the potential of human rights-based laws and policies to improve female sex workers’ health, leading to their greater empowerment. While considerable academic research has been undertaken on sex workers in Kenya, that work has been largely limited to the impact of criminalisation of sex workers as well as the prevalence of HIV and AIDS. There has been a lack of examination of the

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importance of using a Human Rights-Based Approach to secure the sexual and reproductive health and rights of sex workers in the current constitutional environment in Kenya.19

The thesis, therefore, makes an original contribution to the field in four ways: (i) its timeliness enables an up to date analysis of Kenya’s new human rights culture; (ii) it comprises an original piece of empirical research conducted through in-depth interviews and a focus-group discussion to understand the Kenyan context; (iii) it extends transnational feminist theory to the experiences of sex workers and the protection of their sexual and reproductive health and rights in Kenya and the global south in general; and (iv) it provides strategies unique to the study, seeking to respect, protect and uphold sex workers’ sexual and reproductive health rights. Each of these aspects of originality will be expanded upon in order to explain the importance of the research and the contribution it makes to the body of work in this area.

First, the timeliness of the study is emblematic. In 2010, Kenya adopted a new Constitution ushering in a new human rights culture.20 For the first time, the status of international human rights law is explicitly stated in the Constitution of Kenya (2010) compared to the old Constitution, which was silent.21 The Kenyan Constitution incorporates treaties ratified by Kenya into domestic law. Article 2(5) of the 2010


20 Constitution of Kenya 2010, Chapter Four contains a Bill of Rights.

Constitution provides that ‘the general rule of international law shall form part of the law of Kenya,’ which means that international law, including customary international law, shall be a source of law in Kenya. Furthermore, Article 2(6) stipulates that ‘any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution.’ The provisions of international human rights law, particularly the right to the highest attainable standard of health including reproductive health care, are incorporated into the Constitution.

The new 2010 Constitution has been described as ‘the most important political development in Kenya since its independence in 1963’ and ‘one of the most progressive constitutions in Africa.’ However, current scholarship on the Kenyan Constitution has focused on its impact on issues such as land and environmental rights in Kenya, the role of different constitutional institutions, the nature of the Kenyan legal system, corruption and, democracy and executive bureaucracy. A significant amount of research has addressed the right to health at the African regional level, and in Kenya, a focus has been put more broadly on the challenges associated with the enforcement of socio-economic rights in Kenyan courts. Attention to sexual and reproductive health rights in Kenya is limited to a few studies. For example, Rose Oronje’s thesis,

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22 Constitution of Kenya 2010, Article 2(5).
23 Ibid Article 2(6).
24 Ibid Article 43. The Constitution places emphasis on vulnerable and marginalised groups see Article 260 defines ‘marginalised group’ as a ‘group of people who, because of laws or practices before, on, or after the effective date [of the Constitution of Kenya 2010], were or are disadvantaged by discrimination on one or more of the grounds in Article 27(4)’ while Article 27(4) states that: ‘The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.’
‘Understanding the Drivers of Change in Sexual and Reproductive Health Policy and Legislation in Kenya’, reviews the power influencing reproductive health policymaking processes in Kenya, encompassing anthropological concepts. My thesis adopts a different approach. It draws from feminist and socio-legal perspectives. The Kenyan Constitution introduces a culture of human rights with the potential to respect, protect and uphold the human rights of women, especially sex workers, yet no one has investigated the potential of the 2010 Constitution to address, in Kenya, sex workers’ enjoyment of sexual and reproductive health and rights. In addition, more recently, Kenya passed the Health Act (2017) which impacts the subject matter of the thesis addressing contemporary healthcare issues. Moreover, the ‘Nordic Model’ of regulating sex work in Scandinavian countries, aiming to punish the purchase of sexual services, is spreading and is a wider global issue. This study is novel as it seeks to address the compatibility of the Nordic Model with a Human Rights-Based Approach, particularly in the Kenyan context, so as to inform the policy debate there.

Second, the thesis includes an original piece of empirical research focusing on sex workers, non-governmental organisations (NGOs), government officials, health professionals and the police in Kenya, investigating the relatively young human rights culture in Kenya and how marginalised groups are treated in such a new and challenging environment. In particular, the in-depth interviews and focus-group discussion help to determine the focus of the Kenyan government vis-à-vis women’s sexual and reproductive health rights.

Third, the thesis extends, for the first time in Kenya, transnational feminist theory to the lived experiences of women sex workers and their struggles in the Kenyan context so as

to stimulate discussion and encourage the development of rights-based policies that respect, protect and uphold the sexual and reproductive health and rights of sex workers and other marginalised groups in the global south. The thesis builds on postcolonial feminist theory\textsuperscript{36} to enhance the argument that international human rights law has something to offer sex workers in Kenya and women in the global south generally.\textsuperscript{37} Lastly, the thesis suggests strategic ways in which rights-based laws and policies can be meaningfully utilised to alleviate inequalities and discriminatory practices for sex workers to enjoy their sexual and reproductive health and rights. The thesis promises to have an impact and practical implications in Kenya. It will feed back into the work of donor and campaign organisations.

Specifically, this chapter sets out in more detail the gender dimension and motivation of the study (in section 1.1), the research questions and methods (in section 1.2) and the key definitions and concepts utilised in the study (in section 1.3). It also locates the women I am studying in their sociocultural and economic context in Kenyan society (in section 1.4). Finally, it lays out the chapter sequence, explaining how the thesis is organised (in section 1.5).

### 1.1 The Gender Dimension and Motivation for the Study

The enjoyment of sexual and reproductive health and rights, through the application of the national constitution and domestic law, provides the first line of defence for women\textsuperscript{38} as a matter of right, not charity.\textsuperscript{39} Nevertheless, the enjoyment of sexual and reproductive health rights remains weak in Africa and other parts of the world.\textsuperscript{40} Unfortunately, women in Africa, particularly sex workers, face myriad challenges that


\textsuperscript{37} See T Murphy, Human Rights Law in Perspective: Health and Human Rights (Hart Publishing 2013).

\textsuperscript{38} RJ Cook, ‘Enforcing Women’s Rights through Law’ (1995) 3:2 Gender and Development 8, 10; See Pawar, ‘The Adoption of a Rights-Based Approach to Welfare in India’ (n 15) 36.


\textsuperscript{40} Centre for Reproductive Rights (CRR), the International Reproductive and Sexual Health Law Program at the University of Toronto and the Centre for Human Rights at the University of Pretoria, Legal Grounds III: Reproductive and Sexual Rights in Sub-Saharan African Courts (Pretoria University Law Press 2017) 16.
have a severe impact on their lives.\textsuperscript{41} This is not to say that progress has not been made, but rather that the situation is exacerbated when sexual and reproductive health rights in Africa are still subject to ‘controversy, confusion and misinterpretation’.\textsuperscript{42} Critical conversations have to be had. For example, the sexual and reproductive health of vulnerable people in Kenya must be at the centre of Kenya’s international, regional and domestic commitment; and, importantly, sex workers are ‘rights-bearers, not merely ‘beneficiaries’.\textsuperscript{43}

The thesis has a particular gender dimension: it focuses on women. The gender element of sex work plays an important role. While not all sex workers in Kenya are women, they are overwhelmingly female.\textsuperscript{44} Although, on the face of it, the law governing sex workers in Kenya and elsewhere seems to target both male and female sex workers equally, in reality, female sex workers are likely to be the focus of the law more than their male counterparts.\textsuperscript{45} The unequal and extensive treatment applied to female sex workers in Kenya by the law, even when women’s rights are constitutionalised, exposes sex workers to numerous health risks that need to be addressed if they are to enjoy their sexual and reproductive health rights. Mahatma Ghandi once said ‘a nation’s greatness is measured by how it treats its weakest members.’\textsuperscript{46} Women, and sex workers in particular, are especially vulnerable and it is up to states to protect them. Joe Oloka-Onyango asks a fundamental question: ‘[I]f women in general are marginalised, how much more so in the case of African and other Third World women?’\textsuperscript{47} I pose the question: What if these African women are sex workers?

\textsuperscript{41} E Durojaye and G Mirugi-Mukundi, ‘States’ Obligations in Relation to Access to Medicines: Revisiting Kenyan High Court Decision in P.A.O. and Others v Attorney-General and Another’ (2013) 17:1 Law Democracy and Development 24, 40.
\textsuperscript{46} British Healthcare Trades Association, ‘Failing Disabled Children Across the UK: Making the Right Decisions’ (British Healthcare Trades Association 2016) 2.
The criminal status of sex work in Africa, and much of the world, has not only been used to legitimise the mistreatment of sex workers but also supports an apparent widespread acceptance among the general public that such conduct towards these women is justifiable.\textsuperscript{48} For example, sex workers in Kenya are regularly harassed by police, including being coerced into sex to avoid arrest or fines, which in turn, as the World Health Organisation (WHO) observes, makes it difficult for sex workers to report human rights violations to the people who are supposed to protect them.\textsuperscript{49} The injustices and inequalities that impede sex workers’ enjoyment of their sexual and reproductive health and rights in Kenya must be challenged, for they serve to undervalue the lives of sex workers and ignore their very existence.\textsuperscript{50}

In Kenya, where women comprise half the population of approximately 46 million people,\textsuperscript{51} the need for intersection between human rights and sexual and reproductive health is critical for women’s empowerment. Franke Wilmer remarked that ‘a right is like air – those who have it take it for granted but deprived of it, a person finds nothing else matters.’\textsuperscript{52} For those who have not been rights-bearers, or who have only recently been conceded rights, the language of rights not only seems more powerful than it might to those who have long held rights and can take them for granted, but it also is more powerful.\textsuperscript{53} Jotham Arwa cautions that very good human rights law ‘does not automatically lead to the conclusion that the citizens of that country will automatically enjoy their fundamental rights and freedoms to the fullest.’\textsuperscript{54} With the controversy

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\textsuperscript{49} World Health Organisation (n 8) 42.


\textsuperscript{52} F Wilmer, Human Rights in International Politics: An Introduction (Lynne Rienner Publishers Inc 2015) 36.


\textsuperscript{54} Arwa, ‘Litigating Socio-Economic Rights in Domestic Courts: The Kenyan Experience’ (n 32) 438.
\end{flushleft}
surrounding not only sexual and reproductive health and rights but also sex workers in much of Africa, the challenge is even more real and cannot be ignored.  

My motivation for this study began almost ten years ago when I was working at the Federation of Women Lawyers in Kenya and assisting the leading researcher in a project documenting human rights violations of sex workers in Kenya. The majority of sex workers did not want to be recognised as sex workers or, if they did, it was clandestinely for fear of a backlash from society. Sex workers’ voices were generally silenced. As a marginalised group, sex workers continued to struggle against their voices being denied. Working at the Federation of Women Lawyers in Kenya (2007–2012) was an eye-opener to the magnitude of human rights violations that women of all walks of life experienced: more especially the poor women and more so when Kenya operated under the old Constitution, which was described as ‘a major bottleneck’ in the realisation of women’s human rights. Socio-economic rights, such as the right to education, the right to housing and the right to health, were conspicuously absent, and even with many amendments to the old Constitution, there was no serious attempt to include them. Then, the right to life was broadly interpreted to include the right to health. The arrival of the new Constitution in 2010 was a pivotal moment since the right to health, including reproductive healthcare and other rights, was explicitly stated.

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56 The Federation of Women Lawyers Kenya (FIDA Kenya), a national human rights organisation, was established in 1985 around the time of the United Nations Women Conference in Nairobi.
61 Arwa ‘Litigating Socio-Economic Rights in Domestic Courts: The Kenyan Experience’ (n 31) 420.
63 Constitution of Kenya 1963, Section 71(1) ‘No person shall be deprived of his life intentionally save in execution of the sentence of a court in respect of a criminal offence under the law of Kenya of which he has been convicted.’ (Repealed). Other economic, social and cultural rights such as the right to a clean and healthy environment, which is today entrenched in Article 42 of the new Constitution 2010, was equally implied in the right to life.
64 See Constitution of Kenya 2010, Article 43(1)(a) to (f) refers to the right to health, the right to housing, the right to food, the right to clean and safe water, the right to social security and the right to education. Constitution of Kenya 2010, Article 2(5) and (6); NJ Udombana, ‘Interpreting Rights Globally: Courts
Kenyan women, like women elsewhere,\textsuperscript{65} ‘worked no less hard’ in the history of constitutional and law reform, leading to the implementation of these momentous changes.\textsuperscript{66}

1.2 The Research Questions and Methods

The thesis advocates for a human rights-based approach. It argues that an HRBA is necessary if Kenya is to protect and promote the sexual and reproductive health and rights of women. In addressing sexual and reproductive health, it examines sexual and reproductive rights and no single international human rights instrument encompass these rights. A literature review played a key role in developing this approach and the research questions upon which it is based.\textsuperscript{67} The central question of the thesis is whether the adoption of a human rights-based approach can guarantee the sexual and reproductive health of sex workers in Kenya. In asking the central question, the thesis explores four further supporting questions: (a) To what extent have laws and policies adopted a rights-based approach?; (b) What are the mechanisms that promote or deny the enjoyment of sexual and reproductive health rights of sex workers?; (c) What are sexual and reproductive health rights?; and (d) In what ways can sex workers realise their sexual and reproductive health rights?


\textsuperscript{67} T Hutchinson and N Duncan, ‘Defining and Describing What We Do: Doctrinal Legal Research’ (2012) 17:1 Deakin Law Review 83, 112 defines as ‘a precursor to further study – a nexus to that which has been done before.’ RJ Cook, ‘International Protection of Women’s Reproductive Rights’ (1992) 24 New York University Journal of International Law and Politics 645, 655 argues that ‘international human rights law has evolved to regulate the power of states over their own citizens. The price of the denial of reproductive rights is state-ordained continuation of pregnancy or loss of life or health as some of the consequences of the sexual expression of love, non consensual intercourse or rape.’ These rights are critical to the realisation of sexual and reproductive health: the rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; the right to be free from torture or cruel, inhuman or degrading treatment or punishment; the right to privacy; the rights to the highest attainable standard of health (including sexual health) and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one’s children; the rights to information, as well as education; the rights to freedom of opinion and expression, and the right to an effective remedy for violations of fundamental rights.
These questions are addressed in the following order: Chapters three and five answer questions (a) and (b) specifically in sections 3.1, 3.2, 3.3, 5.1.5, 5.2.1, 5.2.2 and 5.2.3 as well as sections 5.1.1, 5.1.2, 5.1.3 and 5.3 which address the hurdles to the enjoyment of sexual and reproductive health rights. These chapters critically examine international and national legal frameworks anchoring human rights entitlements within a framework of laws that underpin human rights-based principles. Chapter six primarily answers questions (c) and (d). The chapter provides original empirical research obtained in fieldwork and amplifies the voices of sex workers on their experiences with the laws and policies on the ground. It examines the understanding of sexual and reproductive health rights including opportunities to enjoy the right to sexual and reproductive health in sections 6.2.1.1, 6.2.1.2, 6.2.1.3, 6.2.1.4 as well as 6.2.2.1, 6.2.2.3 and 6.2.2.5.

The methods employed to answer these questions are set out extensively in chapter four which provides a detailed account of the techniques used in the thesis, including a recognition and discussion of the researcher’s positionality.68 However, what follows below is an overview which briefly summarises the approach taken and how this led to the construction of the thesis in its present form.

I employed a doctrinal method69 to critically analyse human rights and health-related laws and policies at the national, regional and international levels, including decisions in different courts. In terms of secondary sources,70 I conducted a literature review of the existing material on human rights, drawing specifically on material relating to sexual and reproductive health and on sex workers in the global south with a view to showing the challenges and gaps in the existing research.71 I reviewed books from the library and online databases, journal articles, government documents, United Nations

68 F Purwaningrum and A Shtaltovna, ‘Reflections on Fieldwork: A Comparative Study of Positionality in Ethnographic Research Across Asia’ (2017) Open Science Framework <https://osf.io/df3n4> accessed November 2017 note that ‘understanding one’s position in the field is vital to be able to consciously reflect and negotiate space for fieldwork.’

69 Hutchinson and Duncan (n 67) 85 and 107 states that doctrinal research is ‘the research into the law and legal concepts’ and comments further that ‘doctrinal method is similar to that being used by the practitioner or the judge, except that the academic researcher is not constrained by the imperative to find a concrete answer for a client’; M McConville and WH Chui, ‘Introduction and Overview’ in M McConville and WH Chui, Research Methods for Law (Ebook, Edinburgh University Press 2017) 1 assert that doctrinal research ‘focuses heavily if not exclusively upon the law itself as an internal self-sustaining set of principles which can be assessed through reading court judgments and statutes with little or no reference to the world outside of the law.’


71 V Braun and V Clarke, ‘Using Thematic Analysis in Psychology’ (2006) 3 Qualitative Research in Psychology 77, 86.

I used empirical methods to capture the experiences of sex workers in Kenya. I conducted fieldwork for three months in Nairobi: in May, June and July 2015. One focus-group discussion (FGD) was conducted with seven respondents. A total of 18 key informants were interviewed: ten sex workers, someone from the government (Division of Reproductive Health in the Ministry of Health), someone from the Police, a healthcare professional and four people from different non-governmental organisations (NGOs). The selection criteria targeted females 18 years and older and identified as sex workers. These sex workers were identified by a non-governmental organisation (NGO) that works with them and whom, together with other key informants, I identified through my personal and professional networks. Purposive sampling was used to select the participants.

A focus-group discussion (FGD) and semi-structured in-depth interviews were used as methods of data collection. The research tools were in English but I translated them into Kiswahili during the interviews. Kiswahili is Kenya’s national language, and as a Kenyan I am conversant with it. The participants mixed Kiswahili and English during

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72 AM Donley and L Grauerholz, Research Methods (Ebook, Infobase Publishing 2012) 45 notes that qualitative interviews ‘… allow researchers to collect an immense amount of data that can be analysed to produce a thorough understanding of a social phenomenon of interest’.


the interviews. I conducted the focus-group discussion in the offices of the Bar Hostess Empowerment and Support Programme on Jogoo Road in Nairobi. The interviews were carried out in the women’s houses in Korogocho and Kariobangi in Nairobi, while interviews with other key individuals were conducted in different places for their convenience, e.g. their offices, a bar and café shop in Nairobi town city centre and in Kasarani. One interview was conducted by telephone. I personally conducted the FGD and all the interviews and transcribed the data collected in this research. All the interviews were tape-recorded. I took short notes noting non-verbal responses from the respondents while the interview recording proceeded. Each interview took 15–60 minutes. I transcribed the data directly into English, though in most cases participants mixed Kiswahili and English during their interviews.

A total of 19 transcripts were generated. I typed up the transcripts in the months of August and September 2015 and saved each transcript individually as a Word document. To protect the anonymity of the respondents, each transcript was coded, e.g. Sex Worker 1’, ‘Sex Worker 2’ and so forth, it also contained the place where the interview was conducted and the date. The transcripts were secured under a password accessible only to the researcher. The analysis of the transcripts was done manually using a thematic analysis approach to answer the research questions. The study findings are reported in the thesis according to themes that emerged from the data.

Informed consent was obtained from each respondent who participated in the study by asking them to sign a consent form, apart from one respondent whose consent was obtained verbally during a telephone interview. Each of the respondents was given an information sheet which had details about the purpose of the study. In the FGD, I explained the information sheet to the whole group, in particular why their participation was important for the new human rights culture in Kenya as well as the content of the consent form so that they could understand and ask any questions or seek clarity.

77 Rapley, ‘Interviews’ (n 74) 18.
Thereafter, each participant in the FGD signed a consent form and retained a copy of the information sheet. Importantly, the respondents were assured that their privacy and confidentiality would be protected and also informed of their right to refuse to participate in the study or withdraw from the discussion at any time. Ethical approval was obtained from the Cluster-based Research Ethics Committee at the University of Sussex. For guidance on ethics application, I attended a ‘Getting Ethical Approval’ workshop run by the Sussex Doctoral School. Ethical considerations were taken into account before, during and after the study, as stipulated by the Data Protection Act (1998) in the UK.

1.3 Key Definitions and Concepts
A number of key definitions and concepts are used throughout the thesis. For the purposes of clarity these are explained here in the introduction with a view to giving some contextual background and to illustrate how the concepts are used throughout the thesis.

‘Sex work’ in the thesis means the exchange of money or goods for sexual services. I use the term ‘sex work’ because it recognises selling sex as work, rather than ‘prostitution’, although prostitution is used in the explanation and assessment of legislative provisions that directly invoke the language of prostitution because, as Angela Campbell asserts, it ‘resists the victimising and stigmatic insinuations that the term prostitution has historically conveyed’ and resonates strongly with my main argument in the thesis for a Human Rights-Based Approach to sex workers’ enjoyment of sexual and reproductive health rights. ‘Sex workers’ in the thesis are women who receive money or goods in exchange for sexual services, and ‘clients’ are male sex workers’ partners who exchange money or something of value for sex.

81 Donley and Grauerholz Research Methods (n 72) 75 and 81.
82 See J Palmer, D Fam, T Smith and S Kilham, ‘Ethics in Fieldwork: Reflections on the Unexpected (2014) 19:28 The Qualitative Report 1 states that: ‘University Ethics protocols are intended to pre-empt and provide cautionary advice about ethical issues in fieldwork.’
85 Overs, ‘Sex Workers: Part of the Solution – An Analysis of HIV Prevention Programming to Prevent HIV Transmission during Commercial Sex in Developing Countries’ (n 82); See also J Vandepitte, R
that in many contexts in sub-Saharan Africa, to define a sex worker on the basis of paid sex is often unrealistic because sex is exchanged for money or goods by a wide range of men and women.\textsuperscript{86} Intercourse is only one possibility; as Gail Pheterson argues, it may be the norm for some sex workers and the exception for others.\textsuperscript{87} Pheterson remarks that to look at sex work only as sexual intercourse activity, fails to recognise that intercourse implies less flexibility in sex work than is actually the case.\textsuperscript{88} Sex workers conduct their business in different places; their homes, streets, other venues and so forth. These places are referred to in the thesis as ‘hotspots’.

I use the terms ‘human rights-based approach’ or ‘rights-based approach’ interchangeably to mean the application of human rights standards and principles for women to enjoy sexual and reproductive health as a human right. Elsewhere, these words have largely been used interchangeably, including a ‘human rights focus’, or just ‘human rights’, or a ‘rights perspective’ to imply a ‘rights-based approach’.\textsuperscript{89} Critics of a rights-based approach argue that these terms are ambiguous, also that ‘rights-based’ talk requires caution or, in other places, is dismissed as ‘northern hegemony’.\textsuperscript{90} In the study, the ‘right to sexual and reproductive health’ implies that sex workers in the global south, especially in Kenya, are able to enjoy a mutually satisfying and safe relationship with their clients, free from coercion or violence and without fear of infection including HIV and AIDS or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences.\textsuperscript{91} Sexual and reproductive health and rights implies international, regional and national frameworks within which the sexual and reproductive well-being of sex workers in Kenya and the global south can be achieved.\textsuperscript{92}

\begin{thebibliography}{99}
\bibitem{Lyerla} Lyerla, G Dallabetta, F Crabbé, M Alary and A Buvé, ‘Estimates of the Number of Female Sex Workers in Different Regions of the World’ (2006) 82:3 Sexually Transmitted Infections 18.
\bibitem{Carael} M Carael, E Slaymaker, R Lyerla and S Sarkar, ‘Clients of Sex Workers in Different Regions of the World: Hard to Count’ (2006) 82:3 Sexually Transmitted Infections 26, 32.
\bibitem{Ibid} Ibid.
\bibitem{Grushin} Gruskin et al., (n 5) 131 and 136.
\bibitem{Ibid_1} Ibid 131.
\bibitem{Ibid_2} Ibid.
\end{thebibliography}
1.4 Women and the Socio-Cultural and Economic Context in Kenya

Gender equality and women’s empowerment is key for women’s enjoyment of sexual and reproductive health rights in Kenya and much of Africa. For example, women including sex workers should be able to lead long, healthy and productive lives. But, historically, women in different parts of the world, global south in particular have been subjected to systemic discrimination and oppression, often not only founded on negative stereotypes of women, including presumptions rooted in culture and reinforced by social as well as religious attitudes, but also colonialism.

Luise White, *The Comforts of Home*, paints a different picture as she looks at complexity of sex work in the colonial capital city of Kenya, Nairobi. Her work paints a different picture about sex work as she focused on what the women did with their customers and what they did with their earnings. At the time, women accumulated wealth independently from sex work and this was a reliable source of capital accumulation. They were homeowners and landlords. In her approach to colonial sex work history, White recognises the labour contribution of sex workers and presents prostitution as family labour. These women helped resist poverty for themselves and their families. They invested in real estate in the city and some bought goats for their fathers. They subsidised their fathers and brothers farms. White draws attention to the discipline that women in sex work used to conduct their business in relation to their work, time and men as she talks about the powerful role of dignity as well in her ‘True

93 In January 2009, the African States during the 12 Ordinary Session of the African Union Summit in Addis Ababa, declared 2010-2020 as the Africa Women’s Decade (AWD) under the theme ‘Grassroots Approach to Gender Equality and Women’s Empowerment (GEWE)’ and in October 2010 it was officially launched in Nairobi, Kenya. Notably, Kenya ratified the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa in October 2010.

94 Cook, ‘Enforcing Women’s Rights through Law’ (n 38) 9. See also PO Ndege, ‘Colonialism and Its Legacies in Kenya’ Lecture delivered during Fulbright – Hays Group project abroad program: July 5th to August 6th 2009 at the Moi University Main Campus, 2 and 4 provides that Kenya became a British protectorate in 1894 and Africans were subordinated and excluded during the colonial governance and argues that the independent Kenya, did not only inherit but also worsened the colonial crisis of governance; AS Manji, ‘Imagining Women’s ‘Legal World’: Towards A Feminist Theory of Legal Pluralism in Africa’ (1999) 8:4 Social and Legal Studies 435, 443-445 notes that the experience of women with the law both in colonial and post-colonial periods is different. For example, women’s movements was restricted – they needed permission from the local chief, elder or male guardian to travel. In fact they hid in vehicles or bribed drivers. In the interests of both informal traditional system and the colonial authorities, the two sides cooperated to control women customary marriage laws had this purpose. A Stewart, *Gender, Law and Justice in a global Market* (Cambridge University Press 2011) 102-107 where, for example, customary practices that affected women were not only recognised but also legitimised by the colonial state.


96 Ibid 2.
Confessions’. 97 White identifies the following upon which the success of sex workers was dependent:

Their access to secure housing in a tight and expensive housing market and this depended on the good will of their neighbours. Women who shared rooms with employed women, such as domestic servants, refused to meet men in their rooms so as not to jeopardise their friend’s job; women who shared rooms with other prostitutes had clearly defined ways to make sure no one brought a customer home while the other woman was entertaining one. Women spoke of telling the men they met at dances and in the street that they were married and they would have to be discreet: they were not married, but this was the only way they could be sure their customers would behave well when visiting them. 98

At the time when sex workers were associated with venereal disease, White powerfully admitted ‘What was important to my informants was a concept I knew nothing about before I went to Kenya, heshima, ‘respect’ or ‘dignity’, accorded to rank and to the proper conduct. Nothing I had read had prepared me for the place of dignity in Nairobi sex work, but respect and its absence informs this study.’ 99 Arguing that ‘men and male control enter sex work only after the state does,’ White further observes that sex workers were self-employed - controlled their earnings and there were no pimps in Kenya. 100 White contends that the criminalisation of sex work created pimps who controlled over women on the streets. 101

British colonial laws were spread across the British colonies and their impact cannot be overstated. Paula Bartley, Prostitution, provides understanding of the colonial legislative legacy on sex work as it explores the efforts to eliminate sex work from the British society at least between 1860-1914. 102 While Bartley’s work focuses on moral reformers in England, the thesis argues that these colonial legacies have had a lasting impact in the former colonies. Even where the laws of England have changed, in Kenya and other African colonies they have not - even when data has shown the dire consequences of unsafe abortion to women and girls. 103 Alternatively, where it has, the societal attitudes have not. The effects of colonial laws in terms of policing female sex work continue to hurt women sex workers in Kenya, for example. Historically, sex

98 Ibid 142, 143.
101 Ibid.
work was viewed as a female profession and rarely was it male. Sex workers remained the objects of moral scrutiny but not the men who had sex with them. Sex work was looked at as a social evil and sex workers not only as moral criminals but also civil criminals. Attention was drawn to sex work from different sections such as the church, the state, the medical profession, philanthropists, feminists and so forth all of whom provided different solutions to control and eventually get rid of it. Sex work was feared for the reason that it would pervert the marriage, the family, the home and the ‘respectable world’ e.t.c. Efforts were made to put institutions in place that aimed to reform sex workers as well organisations set up to deal with the root causes of prostitution.

This fear, Bartley argues, led to the efforts ‘to regulate and reform the prostitute and to prevent and suppress prostitution.’ During this time, the laws on contagious diseases (Contagious Diseases Acts of 1864, 1866 and 1869), which were subjected to the British colonies, were put in place to make sex work safe for the men in the military. The Criminal Law Amendment Act (CLA) 1885 played two roles - it raised the age of sexual consent for females from 13 to 16 to protect young girls from sex work but also repressive to sex workers and homosexuals. These laws granted police the powers to arrest sex workers and to subject them to medical checks and the sex workers who were found, for example, with sexually transmitted infections were confined until they recovered. Bartley’s study illuminates the relationship between the State and the church. It lends hand to the understanding that the Laws of England were compared with the commandments of God. Whereas sex work was grievous sin, sex workers were sinners who were excluded from the Kingdom of Heaven and condemned to everlasting fire.

104 Bartley (n 102) 32.
105 Ibid 30.
106 Ibid 1 and 32.
107 Ibid 1-2.
108 Ibid 2.
109 Ibid
109 Ibid 32.
110 Ibid.
111 Ibid 12.
112 Ibid 84.
113 Ibid 12.
114 Ibid 32.
The State was obligated to prosecute those who broke the civil law and the church to fight sin. In this case, ‘prostitutes who were found soliciting were charged in the civil courts but others were reminded that they had sinned, not only against the world, but also against God and therefore, like similar wrongdoers, they needed to be punished.’

While women faced the law, men did not. Bartley argues that the legal system penalised sex workers for being sex workers, she also contends that prostitution was not illegal but it was a stigmatised activity, socially unacceptable and surrounded by so many legal restrictions as to be illegal by all but name. Loitering was only a criminal offence when it was practised by women said to be sex workers and not, ‘respectable’ women. From the Victorian era onwards, Teela Sanders et al., argue, the police have enforced the laws surrounding sex work within a context of policing both public spaces and female sex workers.

While reproductive health is neither elitist nor a luxury right, but rather a fundamental right, nevertheless, the obstacles to realising sexual and reproductive health rights are many and Africa carries the greatest burden of sexual and reproductive ill-health. Universal access to women’s sexual and reproductive health in Kenya continues to be constrained by economic, social and cultural factors. These factors form an important background against which to view the challenges sex workers in Kenya face and which make it difficult to enjoy sexual and reproductive health rights. One factor is HIV and AIDS, which continue to be one of the greatest challenges to sexual and reproductive health in sub-Saharan Africa, especially the east and southern Africa regions, and this affects sex workers disproportionally.

115 Ibid 32.
117 Ibid.
120 Crichton et al., ‘Human Rights Abuses and Collective Resilience Among Sex Workers in Four African Countries: A Qualitative Study’ (n 48) 2043.
Despite the significant progress made to prevent HIV infections and scale up HIV treatment efforts in the east and southern Africa regions, reductions in HIV infections remain insignificant.\textsuperscript{124} Women are the ones most affected; they make up more than half of the population living with HIV.\textsuperscript{125} Of the estimated 1.6 million people living with HIV in Kenya, it is further estimated that sex workers comprise approximately 14 per cent.\textsuperscript{126} Moreover, access to treatment for vulnerable groups, such as children and sex workers, is still poor, not to mention HIV-related stigma and discrimination and incoherent policy formulation and implementation, including the lack of adequate budget allocations to the health sector by the Kenyan government.\textsuperscript{127} This is exacerbated when sex workers are seen as women with loose morals\textsuperscript{128} in Kenya and elsewhere. As Sanders et al. argue:

_Historically, sex workers have been portrayed variously as purveyors of disease, a social evil, public nuisance and, more recently, as victims needing to be ‘rescued’ from their abject state. The identity of people working in the sex industry has become inextricably associated with their work selling sex in much policy debate, with little scope for considering them as individuals and rational agents. It is important to stress, however, that sex workers are ‘ordinary’ people and that the fact that they sell sex is a part of their lives rather than a single identifying characteristic._\textsuperscript{129}

Another potential factor is the unmet demand for family planning, which translates into 60 million unintended pregnancies annually in developing countries.\textsuperscript{130} One of the challenges young girls encounter in Africa is the negative attitudes of society to premarital sexual activity.\textsuperscript{131} Many young people are having sex before marriage and young women in particular experience a higher risk of unwanted pregnancy compared to older women.\textsuperscript{132} For example studies show that young people perceive women who carry condoms as promiscuous and so young women especially do not procure

\begin{thebibliography}{99}
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\item[124] World Health Organisation (n 123).
\item[127] Durojaye and Mirugi-Mukundi (n 41) 30.
\item[129] T Sanders, M O’Neill and J Pitcher, Prostitution: Sex Work, Policy and Politics (Online, Sage c2009) 33.
\item[131] Durojaye and Murungi, ‘The African Women’s Protocol and Sexual Rights’ (n 41) 888.
\end{thebibliography}
contraception because of the shame associated with it.\textsuperscript{133} Notably, this is made even more difficult when they ‘receive no basic information about their bodies and reproduction, let alone comprehensive sexuality education that would empower them to make responsible choices and decisions into adulthood.’\textsuperscript{134}

The lack of access to sexual and reproductive health information and services for young women in Kenya, for example, constitutes a violation of their human rights to health, dignity and non-discrimination as guaranteed in international human rights law.\textsuperscript{135} Ordinarily, one of the most effective ways of empowering women, Fathalla et al. argue, is to ‘recognise and enforce their human right to control over their own reproductive systems, enabling them to protect themselves against infection and disease, and against unwanted pregnancies.’\textsuperscript{136} Scholars argue that given the patriarchal nature of most African societies, guaranteeing a woman the right to choose any method of contraception is empowering and will enable her to assert her sexual and reproductive health rights.\textsuperscript{137}

It is, of course, not only in relation to issues of sexuality and reproduction that women face difficulties. Women lack access to basic resources such as employment and property. In terms of employment, while women constitute approximately 50 per cent of the Kenyan population, they account for only 30 per cent of the total formal sector of wage employment and earn, on average, 65 per cent of the wages of men.\textsuperscript{138} With regard to land ownership, while women in Kenya make up 80 per cent of those producing the nation’s food, only about 2 per cent own land. In neighbouring Uganda, where women make up 80 per cent of farmers and produce 60 per cent of the nation’s food, women own only about 1 per cent of the land.\textsuperscript{139}

\textsuperscript{133} Ibid.
\textsuperscript{134} United Nations Population Fund (n 130) 24; See Durojaye (n 21), 387; PM Godia, JM Olenja, JJ Hofman and N van den Broek, ‘Young People’s Perception of Sexual and Reproductive Health Services in Kenya’ (2014) 14 BMC Health Services Research 172.
\textsuperscript{137} Durojaye and Murungi, ‘The African Women’s Protocol and Sexual Rights’ (n 41) 888.
Emmanuel Akyeampong and Hippolyte Fofack, in their work reviewing the impact of colonial policies on African women, show that ‘it is not that women have not been economically active or productive’, rather that ‘they have often not been able to claim the proceeds of their labour or have it formally accounted for’.\textsuperscript{140} In their view, a focus on gender inequality should not only be on the postcolonial and post-independence period, but also on the pre-colonial and colonial period. To ignore the latter, they contend, is narrow and neglects a deeper historical understanding of the processes which shaped the gender relations and dynamics that emerged in the years following independence in Kenya and much of Africa.\textsuperscript{141} A perspective advanced by Patricia Kameri-Mbote who argues that the effects of colonialism on women in former colonies Kenya included have to be considered together with capitalism because the two, she points out, have worked hand in hand to subjugate women both in the family and in the market place.\textsuperscript{142} Women were exposed to social and economic insecurities that they had never experienced before. Kameri-Mbote conveys that the individualised property rights benefited the colonisers and not the colonised societies and observes that these notions influenced significantly the law of marriage and inheritance.\textsuperscript{143}

Men moved into urban centres to work while women were left in the rural areas. This, Kameri-Mbote argues, was a major effect of capitalism.\textsuperscript{144} In the rural areas, women produced for family but also reproduced for the economy. They bore children and gave emotional support to their husbands. In so doing they enabled their men to keep working for their masters. Women did face more burdens because they performed their own tasks as well as those that were traditionally performed by their men. According to White ‘rural African household production subsidised Africans in European employment well into 1940s’ and argues ‘working men literally could not afford to encourage their wives to abandon farming and join them in town.’\textsuperscript{145} Unfortunately, Kameri-Mbote points out that all the tasks performed by women did not translate into their rights and argues that ‘the façade of male supremacy was, and still is, jealously guarded ensuring that women’s work contributes to the family’s estate which is owned by the male head and to which the woman can only expect sustenance as long as her

\textsuperscript{140} Akyeampong and Fofack, ‘Kenya’s New Constitution’ (n 66) 1.
\textsuperscript{141} Ibid 294.
\textsuperscript{143} Ibid.
\textsuperscript{144} Ibid.
\textsuperscript{145} White, ‘Prostitution, Identity, and Class Consciousness in Nairobi during World War II’ (n 100).
In post-independence period, women in the global south face substantial barriers and continue to fight for their rights including their sexual and reproductive health rights. The colonial legacy to the postcolonial countries ‘remains alive issue’.147

It is not surprising that the Kenyan women experience higher unemployment rates compared to men, and despite such gender imbalance, analyses of growth and employment outcomes have largely been gender-blind.148 As in Kenya, a majority of female sex workers in Indonesia, Myanmar, Nepal and Sri Lanka report having entered sex work to support their dependents, particularly their children.149 An HRBA I argue, communicates the language of respecting women’s rights, promoting women’s rights, protecting women’s rights and hence ensuring that their rights are upheld. However, I further argue that universal access to sexual and reproductive health is urgently needed in Africa, but that this can only be meaningful to women if they see it in their daily lives.

Karen Stefiszyn reasons that ‘where doors are closed to women in one organ, windows are often open in another.’150 In the thesis, I use an HRBA approach to understand the vulnerability of sex workers in Kenya, because respect for human rights must be the foundation of any laws and policies that affect all people, including women and sex workers.151 Given the challenges women in Africa encounter, as seen here, coupled with the controversy, confusion and misinterpretation that hinder the enjoyment of the right to sexual and reproductive health, as noted above, the thesis considers it strategic to place this right at the centre of human rights.152

146 Kameri-Mbote, ‘Gender Dimensions of Law, Colonialism and Inheritance in East Africa: Kenyan Women’s Experiences’ (n 142).
150 Stefiszyn, ‘The African Union: Challenges and Opportunities for Women’ (n 10).
152 Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (n 13).
1.5 The Organisation of the Thesis

Following the above preliminary information, the thesis is structured in seven chapters, which sets out the development including chapter one.

Chapter two, *The Theoretical Frameworks*, forms the basis of this study. It critically discusses the framework of the thesis in two-fold: Human Rights-Based Approaches and Feminist Legal Theory. Part I of the chapter considers the significance of using HRBAs to sexual and reproductive health. I use HRBA in the thesis as a framework within which to test whether the Kenyan government, is using normative-based international human rights principles and standards of participation and inclusion, accountability and transparency, non-discrimination and equality, empowerment and the rule of law in its sexual and reproductive health rights policy. HRBAs stresses the interrelation and interdependence of human rights and confer adequate recognition given to the right to the highest attainable standard of physical and mental health to sexual and reproductive health rights by the international human rights law. The chapter contends that despite its criticism, HRBAs place sexual and reproductive health at the centre of rights and has the potential to eliminate discriminatory laws and policies which ultimately provides an environment where women, especially sex workers and other marginalised groups enjoy their sexual and reproductive health rights and live lives of dignity. It also explores the key essential elements to sexual and reproductive health noting that in a HRBA, women are entitled to sexual and reproductive health care goods, services and facilities that are available, accessible (includes affordable), acceptable, and of quality.

Part II of this chapter analyses feminist legal theory because it concerns with the role of law in subordinating women and how the law can be changed for women. As notes Martha A Fineman, ‘feminists are concerned with the implications of historic and contemporary exploitation of women within society, seeking the empowerment of women and the transformation of institutions dominated by men.’\textsuperscript{158} Despite their limitations, relying on feminist postcolonial and transnational feminist theory is important in the thesis to reinforce the significance of a HRBA to the struggles of women Kenya. Postcolonial feminist theory analyses hegemonies of Western scholarship.\textsuperscript{159} It criticises the way in which experiences of women in the global south are told and written particularly by women in the global north and privileged women from the global south.\textsuperscript{160} Transnational feminist theory articulates the importance of sex workers movement in amplifying the struggles of sex workers in silence particularly in the hands of contradictory and discriminatory laws and policies that deny women in sex work, the inherent right to the enjoyment of sexual and reproductive health. It recognises the key role that international human rights law plays in advancing human rights of sex workers including sexual and reproductive health rights at the local, national, regional and international level. The thesis argues that ‘objectification’ and ‘victimisation’ of sex workers in the global south invalidates their voices and denies them the agency and self-determination to make their own sexual and reproductive health decisions.\textsuperscript{161}

Chapter three, \textit{The International and Regional Legal Framework and the Constitution of Kenya in Context} investigates the extent to which international human rights law and the ‘progressive’ and ‘rights-based’ Constitution of Kenya of 2010 protect sexual and reproductive health rights. This chapter argues that despite Kenya having a strong record of ratifying major international and regional human rights instruments,\textsuperscript{162} and

\textsuperscript{158} Fineman, ‘Feminist Legal Theory’ (n 16) 14.
\textsuperscript{160} R Lewis and S Mills, ‘Introduction’ in R Lewis and S Mills (eds), Feminist Postcolonial Theory: A Reader (Edinburgh University Press 2003) 1, 8.
\textsuperscript{162} Vienna Convention on the Law of Treaties 1969, Article 14 provides that as follows
1. The consent of a State to be bound by a treaty is expressed by ratification when:
   (a) the treaty provides for such consent to be expressed by means of ratification;
   (b) it is otherwise established that the negotiating States were agreed that ratification should be required;
   (c) the representative of the State has signed the treaty subject to ratification; or
these being part of its law, Kenyan government has an obligation to ensure that sexual and reproductive health rights are translated into practice. The chapter is categorised into two parts but first, it considers the Cairo Programme of Action and the Beijing Declaration and Platform for Action, whose focus was put on empowering women and protecting their human rights, especially in terms of sexual and reproductive health rights. It underscores the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing to demonstrate how these UN Conferences contributed to advancing global policy norms in respect to sexual and reproductive health rights. In particular, the chapter argues that the Cairo and Beijing documents are fundamental to sex workers because they have concentrated the focus of Kenyan and other African laws and policies, on the sexual and reproductive health rights of women and girls and especially making them usable by sex workers and other marginalised groups.

Part I of the chapter specifically analyses the provisions of selected international and regional human rights instruments to understand international human rights principles and standards. They are: the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Protocol to the African Charter on Human and Peoples Rights’ on the Rights of Women in Africa (the ‘Maputo Protocol’). The focus on these three treaties is due to their advancement of non-discrimination, and the removal of economic, social and cultural barriers that contribute to inequality and vulnerability of sex workers to sexual and reproductive health abuse. It argues that removal of barriers to sexual and reproductive health rights is key for women in Africa to fully enjoy their sexual and reproductive health rights in general. Notably, despite their universal focus of human rights, CEDAW and the Maputo Protocol are politically woman-centred. The Maputo Protocol remains a significant regional human rights

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(d) the intention of the State to sign the treaty subject to ratification appears from the full powers of its representative or was expressed during the negotiation.

2. The consent of a State to be bound by a treaty is expressed by acceptance or approval under conditions similar to those which apply to ratifications.

163 Constitution of Kenya 2010, Article 2(5) and (6).
166 Ibid 73 and 74.
instrument. It explicitly addresses sexual and reproductive health and rights matters such as HIV and AIDS, female genital mutilation and abortion that are pertinent to the African women in the continent. In this part the Kenyan government’s accountability in terms of reporting on its obligations to respect, protect and fulfil sexual and reproductive health rights domestically, to treaty monitoring bodies, is examined. The chapter also reviews concluding observations on the Kenya’s State reports. Part II of chapter two focuses on the Constitution of Kenya 2010. It critically examines the protections to the enjoyment of sexual and reproductive health rights available to sex workers under the Kenyan Constitution to provide a detailed account of the potential impact of this Constitution to sex workers and women in general in a relatively young human rights culture.

Chapter four, *The Methodology*, presents the research methods and techniques used for the original empirical research in the fieldwork.

Chapter five, *The Application of Laws and Policies in the Kenyan Context*, identifies and critically analyses the national laws and policies both in force and proposed, governing sexual and reproductive health rights to evaluate their impact on sexual and reproductive health rights of sex workers and women in general in Kenya including the impact of the British colonial laws. It reviews NGOs shadow reports and outlines the extent to which policies in Kenya comply with the international human rights principles and reviews the legal environment under which sex workers navigate their daily lives as they seek to access their sexual and reproductive health services, goods and facilities.

Chapter six, *The Findings*, presents original piece of empirical research focusing on experiences generated from respondents in the in-depth and focus group discussion conducted during fieldwork in Kenya.

Lastly, chapter seven, *Conclusion and Recommendations*, makes the conclusions and suggestions emanating from the research recognising the key significant role of an HRBA to sexual and reproductive health rights of sex workers in Kenya. It reinforces what is already known about the criminalised nature of sex work in Kenya and much of the global south but extends the knowledge on the use and potential of national, regional and international human rights law to secure enjoyment of sexual and

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168 Committee on Elimination of Discrimination against Women (CEDAW Committee), Committee on Economic, Social and Cultural Rights (CESCR Committee), and the African Commission on Human and Peoples’ Rights (African Commission).
reproductive health rights of sex workers in Kenya. The chapter makes suggestions for further research and sets out concrete terms to better ensure that Kenyan laws and policies promote sexual and reproductive health rights not only of sex workers but, women in general. In so doing, the thesis seeks to contribute to the greater development and empowerment of the many vulnerable and marginalised women in Africa.

We now turn to the theoretical underpinnings of the study in the next chapter in order to demonstrate the importance of application of the theoretical framework to sexual and reproductive health rights, to better understand the role rights and feminist perspective play to the lives of sex workers in Kenya and their situation in relation to law.
Chapter Two

Theoretical Frameworks

Now we [sex workers] have rights. I can even tell a police officer [in his face] that I am a sex worker and that there is nothing he can do to me ... or ask him to arrest me and see if I will not be able to defend myself even before the court. They [police officers] fear you. You see, it is not like before [before the Constitution of Kenya 2010].

Your silence will not protect you.

2.0 Introduction

A human rights-based approach and feminist legal theoretical frameworks underpin this study. Research shows a well-developed international language of human rights in relation to sexual and reproductive health but they remain controversial and contested around the globe particularly in the global south. HRBA stresses the interrelation and interdependence of human rights and confer adequate recognition given to the right to the highest attainable standard of physical and mental health to sexual and reproductive health rights by the international human rights law. The study defines HRBA and locates its origins. It identifies human rights principles (a) participation and inclusion, (b) accountability and transparency, (c) non-discrimination and equality, (d) empowerment, and (e) the rule of law in its sexual and reproductive health rights policy and importantly, whether a HRBA is used to ensure sex workers sexual and reproductive health rights are promoted and protected as ‘human rights-holders’. The thesis utilises an HRBA as a framework for policy making and a means through which to hold the Kenyan government accountable in its constitutional commitments.

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1 Interview with Sex Worker 7 (Nairobi, 15 July 2015).
provides an advocacy strategy for activists and citizens particularly those whose rights are often ignored.

In Kenya, the government says out rightly in its Health Policy 2014-2030 that:

*The national and county governments will put in place measures to progressively realise the right to health as outlined in Article 21 of the Constitution. The sector will employ a human rights-based approach in healthcare delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programmes. This includes human dignity; attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalised groups, and older members of the society (Constitution of Kenya 2010 Article 53–57); and ensuring that health services are made accessible to all.*

In addition, the Kenyan government in its National Reproductive Health Policy 2007, states that ‘Implementation of this policy should be guided by adoption of evidence-based practices, a human rights approach, quality improvement, standard setting and audit, and application of appropriate and cost-effective technologies’ (italics are my emphasis).

Claiming the rights of women in a world of blatant gender hierarchies as Susanne Zwingel, argues, is an international feminist strategy that has been around for a long time. While the scope and content of human rights remain contested, many women’s rights activists around the world rely on the human rights framework in their struggles in local, national, regional and global justice. I use postcolonial transnational feminist theory to interrogate whether HRBAs can help women in the global south more so, vulnerable and marginalised groups such as sex workers to realise sexual and reproductive health rights. Section 2.1 explains what HRBAs are as well their criticisms (in section 2.2). Section 2.3 examines the impact of HRBAs while transnational feminist legal theory is discussed (in section 2.4).

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6 Kenya Health Policy 2012-2030 (Kenya), 30.
9 Ibid 345.
2.1 Human Rights-Based Approaches

The Origins

Roosevelt’s remarks, in chapter one, reminds us many decades later that human rights matter for everyone and everywhere, including for women in the global south. Human rights-based approach arose within the international cooperation context – at the time, development was a focus for the economists and human rights for lawyers and activists.\(^{11}\) The two started to merge when countries in the global south started to join the UN after their independence in the 60s and 70s.\(^{12}\) Cornwall and Nyamu-Musembi trace the origins and growth of human right-based approaches to the discourse of international development agencies in the early 1990s and the World Social Development Summit at Copenhagen in 1995.\(^{13}\) They assert that human rights emerged stronger after the Second World War as encompassing civil, political, social and cultural rights and that the principles articulated as part of the human rights-based approach are not new.\(^{14}\)

Morten Broberg and Hans-Otto Sano describe the attention to human rights following the atrocities of Second World War as ‘an instrument of transformation and justice’ that subsequently led to the decolonisation process especially in Africa and Asia.\(^{15}\) However, Cornwall and Nyamu-Musembi, articulate that the HRBA principles had been part of struggles of self-definition and for social justice long before the rights discourse went global after the Second World War particularly in countries in the global south.\(^{16}\) They argue that many of the tensions and possibilities that flow from the articulation of a

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\(^{12}\) Ibid.


\(^{14}\) Ibid 11 and 13; see also Charter of the United Nations 1945, Article 1(3) stipulates that ‘to achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion’ and Universal Declaration of Human Rights (UDHR), GA Res. 217 A (III) (1948), The Preamble proclaims the Declaration ‘as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.’


rights-based approach to development should be understood as emergent from longer-standing relations between states, powers and institutions involved in rights discourse.\(^ {17}\) They convey that rights talk was and indeed remains a defining feature of resistance and liberation movements in the global south.\(^ {18}\) Rights were used to frame demands for self-rule against constraints imposed during the colonial regime where, for example, citizens were not conferred the right to citizenship and other entitlements and were excluded participating in making decisions in the matters that affected them.\(^ {19}\) The colonised including women had to fight against the colonial rule for their citizenship – women in much of Africa and global south, for example, Nigeria, Zimbabwe, Kenya, South Africa and India, participated in the struggle against injustice.\(^ {20}\) Rights arose from the act of struggling – opposition to colonial rule.\(^ {21}\)

While a range of actors have made important contributions to the evolution of human rights-based approaches, the UN has been central.\(^ {22}\) Sofia Gruskin et al., observes that rights-based approaches grabbed a global attention when the then United Nations Secretary General, Kofi Annan, called for the United Nations to integrate human rights into all of its work.\(^ {23}\) In 2003, United Nations agencies agreed on the United Nations Common Understanding, affirming that all development programmes and assistance should realise human rights and be guided by human rights principles and standards.\(^ {24}\) The Office of the United Nations High Commissioner for Human Rights (OHCHR) defines a human rights-based approach as a

*Conceptual framework for the process of human development that is normatively based on international human rights standards and operations directed to promoting and protecting human rights. It seeks to analyse inequalities which lie at the heart of*

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17 Ibid.
18 Ibid.
19 Ibid.
21 Cornwall and Nyamu-Musembi, ‘Putting the ‘Rights-Based Approach’ to Development into Perspective’ (n 11) 1421.
Sex workers in Kenya are learning that they have rights especially with the new constitutional dispensation and NGOs working with sex workers play a crucial role in helping translate rights into the sex workers programmes at the local level as well as seize and claim them from the government. The organisations appropriate, translate and remake transnational discourses into the vernacular. For the first time since independence, sex workers are engaging with the human rights treaty bodies e.g. CEDAW Committee at its 68th Session as discussed in chapter three. To women, especially sex workers and other key populations, human rights offer hope and ‘tools and consciousness to fight back.’ In her work translating international law into local justice, Sally Merry is concerned with how global law is translated into the vernacular. Rights offers, Merry contends, a new vision of the self as entitled to protection by the state, however, she argues, the promise must be fulfilled. But when rights are not transformed into the local context, Merry argues, they are ‘ornamented by local cultural signs and symbols and tailored to local institutions.’ She evaluates the global human rights system which she notes, is deeply transnational and importantly, not exclusively rooted in the West.

HRBAs are viewed as an empowering approach that stems from the 1948 Universal Declaration of Human Rights (UDHR) affirming that women including those in sex work have justifiable entitlement. UDHR recognises the inherent right to dignity for every human being to among others, health. The Preamble states, ‘recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.’ The adoption of the General Assembly of the UDHR in 1948 has been followed by several international

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27 Ibid 2.
28 Ibid
29 Ibid 217.
30 Ibid 216.
31 Charter of the United Nations, Article 1(3).
conventions and covenants, which promote human dignity and worth, to basic SRH goods, services and facilities.

Research shows a well-developed international language of human rights in relation to sexual and reproductive health but SRHR remain controversial and contested in much of the global south. The international discourse of human rights have influenced policy making and programming for SRH and this, it is argued, has permeated national and local debates and practices. This study furthers the debate in understanding the relationship between rights and SRH and their relevance in the daily lives of women who do sex work in the global south.

HRBAs are grounded and gain its legitimacy from international human rights law. An HRBA to SRHR aims to realise the right of sex workers to the enjoyment of the highest attainable standard of physical and mental health and other health-related human rights. Under international human rights law, States in the global south have three primary responsibilities: to respect, protect and fulfil SRHR of sex workers. The obligation to respect SRHR puts a duty on the government not to interfere whether directly or indirectly with their enjoyment. They are for example, refrained from limiting access to sexual and reproductive health goods, services and facilities. The requirement to protect SRHR places on the governments the obligation to prevent third

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36 Ibid.
37 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 47.
parties such as clients, spouses or neighbours from interfering with these rights.\textsuperscript{41} On the other hand, to fulfil SRHR of sex workers the governments are required to ensure their full enjoyment and to do so they have to adopt appropriate legislative, administrative, budgetary, judicial, or other measures.\textsuperscript{42}

Despite criticisms,\textsuperscript{43} scholars argue that HRBAs provide a wider view of the right to health.\textsuperscript{44} For example that the sex workers’ enjoyment of SRHR cannot be done in isolation, as Shirley Gabel puts it ‘a range of rights work in tandem.’\textsuperscript{45} SRHR is dependent on other human rights such as the right to information, the right to dignity and the right to non-discrimination. Alicia Yamin and Rebecca Cantor remind us that ‘we cannot lose sight of the aim of using … [HRBAs] to transform society, which often entails messy, and inherently political, contestation.’\textsuperscript{46}

Alicia Yamin argues that HRBAs are seen to address violations of women’s SRHR across their lives rather than to simply promote ‘technical fixes’.\textsuperscript{47} In HRBAs the policy process and outcome are key elements to the right to health. Francisco Songane remarks that an HRBA to be effective and truly rights-based, it must be explicit from the very beginning of health strategy development and project planning.\textsuperscript{48} Yamin puts it that HRBA needs to influence decisions at every stage of decision making from the initial situational analysis, and design of a national strategy and plan of action on for example sexual and reproductive health, to specifics on budget formulation and implementation, to programme implementation, to monitoring and evaluation, with the specific aim of creating what she terms a ‘circle of accountability’.\textsuperscript{49}

\textsuperscript{41} Ibid.
\textsuperscript{42} Ibid.
\textsuperscript{44} Hunt, ‘Interpreting the International Right to Health in a Human Rights-Based Approach to Health’ (n 43) 110.
\textsuperscript{49} Yamin, ‘From Ideals to Tools: Applying Human Rights to Maternal Mortality’ (n 47) 4.
Wouter Vandenhole and Paul Gready affirm that HRBAs are norm-based whereas development approaches are more evidence-based. HRBAs have the potential to provide what Cornwall and Nyamu-Musembi have described as ‘powerful approach to development’. HRBAs are viewed as useful frame that offers participation and empowerment although it is also argued that invoking distant international human rights standards present its own challenges and that contextual factors have to be put into perspective. To ground SRH to human rights means that HRBAs draw on the legal codification of human rights and norms and standards in the international and regional human rights treaties including the work of treaty monitoring bodies and at the national level, the national laws and the human right monitoring bodies.

At the international level the United Nations human rights treaty bodies known as ‘committees’, monitor the implementation of the core United Nations human rights instruments through reporting, complaints and inquiry. For example, the Committee on Economic, Social and Cultural Rights (CESCR) is mandated to monitor the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Committee on the Elimination of Discrimination against Women, monitors the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). At the regional level, Americas, European and African human rights systems have judicial monitoring regime in place, that is, the Inter-American Court of Human Rights, European Court of Human Rights and the African Commission on Human and Peoples’ Rights. At the domestic or national level human rights institutions and courts monitor human rights, e.g. the Kenyan National Commission on Human Rights (KNCHR). The civil society in the global south can use HRBAs to

31 Cornwall and Nyamu-Musembi, ‘Putting the “Rights-Based Approach” to Development into Perspective’ (n 11) 1418.
32 Ibid.
34 Vandenhole and Greedy, ‘Failures and Successes of Human Rights-Based Approaches to Development: Towards a Change Perspective’ (n 50), 293-294.
37 Vandenhole and Greedy, ‘Failures and Successes of Human Rights-Based Approaches to Development: Towards a Change Perspective’ (n 50), 294; See also Principles Relating to the Status of National Institutions (The Paris Principles) GA Res 48/134, para 1 mandates national human rights institutions to promote and protect human rights.
test their governments health and related policy choices set by international human rights standards, yet impede the progressive realisation of SHRH of sex workers.\textsuperscript{58}

According to Cuttice and Exworthy, an HRBA, is the process that enables the protection of human rights.\textsuperscript{59} Rights are depicted and I agree with this view, as ‘a protection of the weak against the strong, or the individual against the state. No matter how (in)effective they are in achieving such protections, there is little doubt that a reduction in rights is equated with a loss of power or protection,’ notes Carol Smart.\textsuperscript{60} For Gabel human rights are ‘integral to the enjoyment and safeguarding of human life, the achievement of human progress, the protection of human dignity, and the advancement of human security.’\textsuperscript{61} Because HRBAs are based on international human rights law, it anchors health in a system of rights. Despite problems with rights, a human rights lens on health helps to shape understandings of ‘who is disadvantaged and who is not; who is included and who is ignored; and whether a given disparity is merely a difference or an actual injustice,’ argues Gruskin et al.\textsuperscript{62} Yamin’s research on human rights frameworks advances the argument that HRBAs provide a framework through which to identify rights holders, duty bearers, freedoms and entitlements, and obligations.\textsuperscript{63} They show in particular, who has rights and what rights they have under international human rights law, including who is responsible for making sure rights holders are enjoying their rights.\textsuperscript{64} Cornwall and Nyamu-Musembi illuminate the fact that the State is the principal duty-bearer with respect to the human rights of its people, however, they point out that the international community has a responsibility to help realise universal human rights including SRHR.\textsuperscript{65}

HRBAs require that root causes to inequality in the provision of SRH be addressed recognising that women’s inherent dignity entitles them to these rights and that the said

\textsuperscript{58} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 67.
\textsuperscript{60} C Smart, \textit{Feminism and the Power of Law} (Routledge 1989) 143.
\textsuperscript{61} Gabel, \textit{A Rights-Based Approach to Social Policy Analysis} (n 45) 4.
\textsuperscript{62} Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 129.
\textsuperscript{64} Ibid.
\textsuperscript{65} Cornwall and Nyamu-Musembi, ‘Putting the ‘Rights-Based Approach’ to Development into Perspective’ (n 11) 1417.
rights cannot be taken away. What is more, scholars argue, HRBAs give priority to severe or gross types of rights violations even if these violations concern a small group such as sex workers and other marginalised groups. Gabel argues that rarely in a rights-based approach is one right violation isolated which echoes intersectionality feminist Kimberlé Crenshaw’s argument that women do not live a single issue lives. For instance, Crenshaw argues that the adoption of a single-issue framework marginalises the very people who are supposed to be protected and creates ‘illusive goal’ to end patriarchy difficult to attain. With this in mind, one cannot choose which rights to ignore and those to observe, argues Leslie London.

2.1.1 The Core Principles of Human Rights-Based Approaches

The concept of a right to health as a human right Virginia Leary comments, emphasises social and ethical aspects of health care and health status, as these aspects are embodied in the principles underlying all international human rights. The right to health is developed in the thesis by focusing and applying those principles to the right to sexual and reproductive health of sex workers. In so doing, emphasis is put on the States to ensure for example that the right to equality and non-discrimination is respected, protected and fulfilled. HRBAs require that Kenya formulate its legislative and policy framework taking human rights obligations into account. HRBAs provide a framework for more effective analysis and to identity the wider range of solutions needed. For example Twomey points out that ‘economic growth alone is not sufficient to reduce poverty – growth needs to be combined with policies designed to reduce

66 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 3) 68.
67 Cornwall and Nyamu-Musembi, ‘Putting the ‘Rights-Based Approach’ to Development into Perspective’ (n 11) 1417.
68 Gabel, A Rights-Based Approach to Social Policy Analysis (n 45) 29.
74 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 50.
75 Ibid 67.
inequality. HRBAs, Hans Hugen argues, ‘determine the requirements of the relevant processes that must take place to ensure the best realisation of human rights.’ Hugen refers to this as ‘obligation of conduct’. The principles and human rights standards, that is, participation and inclusion, accountability and transparency, non-discrimination and equality, empowerment and the rule of law should be integrated at all levels of policy-making regarding sexual and reproductive health rights. International human rights principles and standards are ‘lens’ or ‘pillars’ through which States’ commitment to health, including sexual and reproductive health should be evaluated inasmuch as they remain contested.

*Participation and Inclusion*

Participation and inclusion is a core principle of HRBAs. It requires that sex workers participate actively, freely and meaningfully in the formulation and implementation of laws and policies that affect their sexual and reproductive health rights and their views taken into account. Rights talk, according to Cornwall and Nyamu-Musembi, provides a new frame within which to signal a move towards a more genuinely inclusive and democratic process of popular involvement in decision making over the resources and institutions that affect people’s lives. They argue that a rights-based participation is about shifting the frame from assessing the needs of beneficiaries or the choices of customers or clients, to foster citizens to recognise and claim their rights and obligation-holders to honour their responsibilities. The principles of participation are embedded in the 2010 Constitution of Kenya and this does not only raise the sex workers hopes high of being listened to but also offer means for sex workers to challenge unfair

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76 Ibid 68.
78 Ibid.
80 Yamin and Cantor, ‘Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health’ (n 46) 457.
82 Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 139.
84 Ibid.
government policies.\textsuperscript{85} Assessment of inequality has to be continuous and capacity development conducted to ensure meaningful participation.\textsuperscript{86} WHO recognises the importance of participation in health matters and the Declaration of Alma-Ata provides, ‘The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.’\textsuperscript{87}

Patrick Twomey finds participation empowering, although to ensure meaningful participation he argues, questions have to be asked as to ‘who should participate? Who decides who participates? In what form/process is participation ensured? Where should ultimate decision-making power rest?’\textsuperscript{88} Participation needs to be managed so that voices that are not commonly heard in decision-making processes such as women and other marginalised groups like sex workers are included, Twomey argues.\textsuperscript{89} Scholars argue that human rights-based approach has the potential to make a ‘top-down’ policy into ‘bottom-up’ to generate meaningful change.\textsuperscript{90} Participation and inclusion equally raises a question of literacy. Information sharing is critical in empowerment, for instance, the information on sexual and reproductive health rights has to be available both on time and it has to be in a language accessible for sex workers to make meaningful contribution. When sex workers are not involved, decisions are often made which leave them vulnerable to the outcome of the processes that they have not adequately participated in.

\textit{Accountability and Transparency}

Ratification of international human rights treaties does not guarantee the respect, protection, and fulfillment of human rights but, argues Brigitte Hamm, it supports the accountability of the States.\textsuperscript{91} Hence, ratification and withdrawal of reservations from major international human rights treaties is important. Accountability and transparency

\textsuperscript{87} Declaration of Alma-Ata (International Conference on Primary Health Care Alma-Ata USSR 6-12 September 1978) IV.
\textsuperscript{88} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 47.
\textsuperscript{89} Ibid.
requires Kenya to have clear and transparent accountability mechanisms in place for decision-making, review, and redress of human rights.\textsuperscript{92} Twomey sees HRBAs as approaches that facilitate transparency and wider endorsement of national development processes.\textsuperscript{93} Yamin assert the view that accountability can be used to improve policy making by identifying systemic failures that need to be addressed in order to make for example the delivery of health services more effective and responsive.\textsuperscript{94} In so doing Twomey remarks that, it requires identification of both claim holders and their entitlements, duty bearers and their obligations and the duty bearers’ positive obligation to protect, respect and fulfil as well as the negative obligations to abstain from violations of different actions.\textsuperscript{95} All stakeholders should have clear understanding of where responsibility lies and to whom they can bring complaints.\textsuperscript{96} Peter Uvin points out that ‘claims bring a focus on mechanisms of accountability. If claims exist, ‘methods of holding those who violate claims accountable must exist as well. If not, the claims lose meaning.’\textsuperscript{97} Clare Ferguson, however, asserts that talking about rights, provides a ‘vehicle for increasing the accountability of government organisations to their citizens and consequently increasing the likelihood that policy measures will be implemented in practice.’\textsuperscript{98} Twomey sums up that:

\begin{quote}
Accountability is about translating universal standards into local benchmarks for measuring progress and developing effective laws, policies, institutions, procedures, and mechanisms of redress that ensure delivery of entitlements and redress for denial and violations.\textsuperscript{99}
\end{quote}

States’ accountability can be through reporting on human rights treaties for example the Convention on the Elimination of All Forms of Discrimination against Women incorporating the right to sexual and reproductive health, review of health policies as well as constitutional reviews. The regular and transparent monitoring and evaluation,

\textsuperscript{92} Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 139.
\textsuperscript{93} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 67.
\textsuperscript{94} Yamin, Power, Suffering and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter (n 63) 134.
\textsuperscript{95} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 54.
\textsuperscript{96} Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 139.
\textsuperscript{97} P Uvin, Human Rights and Development (Kumarian 2004) 131 cited in Cornwall and Nyamu-Musembali, ‘Putting the ‘Rights-Based Approach’ to Development into Perspective’ (n 11) 1417.
\textsuperscript{99} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 55.
would help States in increasing their compliance with their international commitments.\textsuperscript{100}

\textit{Non-discrimination and Equality}

Non-discrimination and equality are fundamental human rights principles and critical components of the right to health including sexual and reproductive health.\textsuperscript{101} Article 2 of the UDHR provides, ‘Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind such as race, colour, sex, language, religion, political or other opinion, national or social origin.’\textsuperscript{102} HRBAs require States to prohibit, prevent and eliminate all forms of discrimination against women through its laws, policies and practices.\textsuperscript{103} For example the lack or limited access to sexual and reproductive health services including criminalisation orchestrated on those accessing or providing such services is the result of discrimination against women and girls including gender stereotype.\textsuperscript{104} The law that discriminates undermines the rule of law both of which are significant in a human rights-based approach. For example in \textit{Ghaidan v Mendoza}, Lord Nicholls of Birkenhead stated that: ‘Discrimination is an insidious practice. Discriminatory law undermines the rule of law because it is antithesis of fairness. It brings the law into disrepute. It breeds resentment. It fosters an inequality …’\textsuperscript{105} HRBAs require that discrimination and protection of vulnerable groups for example as sex workers, persons with disabilities, and persons living with HIV or AIDS are treated as a priority.\textsuperscript{106} To address the human rights of vulnerable people or to use Gruskin et al., term, ‘difficult-to-reach populations’,\textsuperscript{107} Twomey asserts that


\textsuperscript{102} Universal Declaration of Human Rights (UDHR), GA Res. 217 A (III) (1948), Article 2.

\textsuperscript{103} CEDAW, GA Res. 34/180 (1979), Article 1.

\textsuperscript{104} OHCHR, ‘The Mandates of the Chairperson-Rapporteur of the Working Group on the Issue of Discrimination against Women in Law and in Practice, the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, and the Committee on the Elimination of All Forms of Discrimination against Women’ (n 100).

\textsuperscript{105} [2004] UKHL 30, [9].

\textsuperscript{106} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 3) 54.

\textsuperscript{107} Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 139.
disaggregated data by race, sex, ethnicity, age, language, religion, disability, property, birth or other status is essential and needs to be available.\textsuperscript{108} Essentially, HRBAs support the right of disadvantaged groups to be counted and reduce vulnerability.\textsuperscript{109} Yamin and Cantor call for disaggregated data and point out the need to understand what to count and why.\textsuperscript{110} It is important to note that this data should be transparent and available to everyone without compromising confidentiality.

\textit{Empowerment}

As a feminist research, the empowerment of women is critical, more so, the traditionally marginalised women who do sex work in the global south.\textsuperscript{111} In an HRBA, women are required to know their rights and subsequently claim them.\textsuperscript{112} The claims of human rights violations for example, can be used to bring attention to sex workers and justify outside pressure on the state to oblige to its commitments to respect, protect and fulfill their rights.\textsuperscript{113} A claim for an issue such as HIV treatment or abortion as a right for sex workers gives it legitimacy and makes it popular even when not everyone agrees with it.\textsuperscript{114} According to Carol Smart, ‘it enters into a linguistic currency to which everyone has access.’\textsuperscript{115} International, regional and national laws and policies can make a difference if sex workers are not only empowered to use their rights but also knowing what they can do if their rights are violated.\textsuperscript{116} Those at the front line of programme or project implementation, play a vital supportive role in women’s empowerment as Cornwall cautions that the best of laws and policies and most beautifully designed programme can falter and fail if those who deal with putting them into practise are not themselves engaged and empowered as agents of change.\textsuperscript{117}

\textsuperscript{108} Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 67.
\textsuperscript{110} Yamin and Cantor, ‘Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health’ (n 46) 471.
\textsuperscript{112} Ibid.
\textsuperscript{114} C Smart, Feminism and the Power of Law (Routledge 1989) 143.
\textsuperscript{115} Ibid.
Rule of Law

The rule of law requires that the State parties and in this case the Kenyan government and other duty bearers are answerable for observance of human rights in relation to women.\textsuperscript{118} The States have to comply with legal norms and standards enshrined in human rights instruments.\textsuperscript{119} HRBAs in respect to women’s rights require that where States fail to comply with minimum human rights standards, aggrieved rights-holders, the women, be entitled to institute proceedings for appropriate redress before courts or other domestic or international human rights mechanisms.\textsuperscript{120}

These principles should form the core of the requirements on the conduct of any laws and policies\textsuperscript{121} on sexual and reproductive health rights in Kenya. In application, consistency is key, I argue. In addition, in order for sexual and reproductive health rights to be realised, it is important that related goods, services and facilities meet the ‘basic right to health test’ – that is, availability, accessibility (includes affordability), acceptability and of good quality as discussed below. These key elements are fundamental to inform the adequacy of human rights policies or better what Hans Haugen refers to as, ‘obligation of results’.\textsuperscript{122}

2.1.2 The Key Elements of Sexual and Reproductive Health

The enjoyment of sexual and reproductive health rights require that sexual and reproductive health facilities, goods and services must be available, accessible, affordable and good quality for all, especially the most vulnerable or marginalised sections of the population e.g. women more so female sex workers, people living with HIV and AIDS and same sex without discrimination.\textsuperscript{123} The right to sexual and

\textsuperscript{118} OHCHR, ‘Frequently asked Questions on a Human Rights-Based Approach to Development Cooperation’ (United Nations 2006) 36.
\textsuperscript{119} Ibid.
\textsuperscript{120} Ibid.
\textsuperscript{121} Ibid.
\textsuperscript{122} Ibid.
\textsuperscript{123} UN Human Rights Council, Report of the Special Rapporteur on the Rights of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health A/HRC/14/20, para 3.
reproductive health refers to the right to the enjoyment of a variety of goods, facilities, services and conditions necessary for its realisation.\textsuperscript{124}

In an HRBA, women are entitled to sexual and reproductive health care goods, services and facilities that are available, accessible (includes affordable), acceptable, and of quality (‘Triple A and Q approach’).\textsuperscript{125} The ‘Triple A and Q approach’ is to use Damon Barrett term, a ‘basic right to health test’.\textsuperscript{126} Maya Unnithan posits that to talk of human rights standards as applied to health systems means to focus the governments’ attention on maximising availability of health facilities, goods, and services in sufficient quantity – it includes a functioning public health.\textsuperscript{127} Accessibility means that sexual and reproductive health goods, services and facilities are provided without discrimination to women.\textsuperscript{128} It also implies the right to seek, receive and impart health-related information in an accessible language and format - this does not give away women’s right to have their personal data and information treated strictly confidential.\textsuperscript{129} Acceptability, on the other hand means sexual and reproductive health goods, services and facilities are culturally acceptable and appropriate, while quality entails providing medically sound sexual and reproductive health services of highest quality.\textsuperscript{130} It requires trained health professionals, scientifically approved and unexpired drugs and hospital equipment.\textsuperscript{131}

2.1.3 Criticisms of Implementing Human Rights-Based Approaches

While human rights-based approach strengthens law and legal arguments that can be used to address discrimination and inequality, scholars argue this approach promote inequality and conflicts between different groups in society and this could lead to

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\textsuperscript{126} Ibid.
\textsuperscript{128} Ibid.
\textsuperscript{130} Ibid.
preference being given to some groups; promote non-sustainable use of natural resources where notably, one group obtains control over another or others; and promote inappropriate governance especially because rights can be used to secure increased power at the expense of others.\textsuperscript{132} Some critics are cautious about the value of human rights.\textsuperscript{133} Shazia Qureshi argues that the notion of human rights law is not ‘value-free’, but that its agenda is both political and gendered.\textsuperscript{134} Qureshi contends that the human rights conceptual framework is deeply gendered and it privileges a certain set of normative commitments.\textsuperscript{135} She asserts that the legal construction of human rights is unsatisfactory for women because the core theme of human rights law reflects a male viewpoint which may not necessarily resonate with the lived realities of women’s lives\textsuperscript{136} and that the way they are implemented, they are gendered.\textsuperscript{137} Even though in most cases States enforce human rights through its laws upon ratification of international human rights treaties, Auwais Rafudeen argues that they do not necessarily enforce their provisions.\textsuperscript{138} Human rights-based approach require adoption of an approach explicitly shaped by human rights principles as note above,\textsuperscript{139} but, Gruskin et al argue that the challenge exists particularly in countries in the south when the awareness of human rights among policy makers and the political will for implementation remain low.\textsuperscript{140} Brigitte Hamm points out that:

\textit{A human rights approach to development can be successfully implemented only when those responsible and involved (in ministries and international organisations as well as the people concerned) know human rights in depth. They not only should think of human rights as an inspiring moral idea but also need to know the existing human rights system of the UN. Therefore, both development agents and the people concerned must receive the human rights education necessary in order to become familiar with human rights standards, including the most important treaties and instruments of implementation and monitoring. Such knowledge cannot be taken for granted.}\textsuperscript{141}

Radhika Coomaraswamy argues that the legal system is ‘perverted’ by political will while in essence women’s human rights are manipulated by e.g. religion.\textsuperscript{142} Instead, Coomaraswamy suggests a ‘political mobilisation from within and international support from without.’\textsuperscript{143} Crenshaw offers critique beyond ‘political will’. She argues that it is ‘due to the influence of a way of thinking about discrimination which structures politics so that struggles are categorised as singular issues. Moreover, this structure imports a descriptive and normative view of society that reinforces the status quo.’\textsuperscript{144} In addition, governments can be hostile to HRBAs particularly when health-related rights are ‘judicialised’ as it is viewed as a challenge to the principles of separation of powers, claims Yamin and Cantor.\textsuperscript{145} However, while courts in some jurisdictions have avoided ‘encroaching’ on the executive, courts in other jurisdictions have not shied away from holding the government accountable to its national and international human rights obligations.\textsuperscript{146}

Some scholars argue that to assert a legal right is to affirm that social power rests in the State and not in the people.\textsuperscript{147} Critics of rights argue that rights protect privileged groups in society and in their view rights promote individualism ignoring natural relationships and the fact that these relationships are born out of social life.\textsuperscript{148} Sylvia Tamale argues that the separation of the issues that affect women as private and not public has been attributed to the colonial laws which did not extend ‘rights’ to the domestic or private sphere.\textsuperscript{149} Tamale avers that the post-independence constitutions\textsuperscript{150} of many African countries exempted personal laws for example marriage, divorce,

\textsuperscript{143} Ibid.
\textsuperscript{145} Yamin and Cantor, ‘Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health’ (n 46) 458 and 459.
\textsuperscript{146} Ibid.
\textsuperscript{147} Charlesworth, ‘What are “Women’s International Human Rights”?’ (n 111) 60.
\textsuperscript{148} Ibid 60-61.
\textsuperscript{150} For example Malawi, Nigeria, Zambia and Kenya.
adoption, burial, inheritance and succession, from the protection of law against discrimination.  

A HRBA is sometimes viewed with suspicion in the global south as an external influence from the West. Arguably, the concerns are in most cases in good faith although they are also said to mask a desire to avoid human rights obligations. Different countries in Africa today reflect the international human rights standards articulated in international human rights instruments in their national laws and policies but fail in their implementation to secure women’s rights. They lack consistency I argue. Carol Smart in the *Feminism and the Power of Law* encourages looking for non-legal strategies and questions looking to law to liberate women or solve their problems. Sally Merry’s study on law and colonialism steered her to conclude that: ‘Law often serves as the handmaiden for processes of domination, helping to create new systems of control and regulation.’

But Craig Lind, argues that:

*The legal system is merely one of the tools society uses to bolster its dominant norms. If those norms establish unequal distributions of power, law simply entrenches that inequality. However, when a society does set out to subvert its tradition of inequality using law it must do so carefully. Because law is not the whole of the problem a very creative use of law as a solution is required. That solution must address itself to more than just the formal inequality of people. It must take account of the social conditions in which inequality flourishes.*

Lind echoes Carol Smart’s position that in effect law can remedy past injustices by imposing its own power in the interests of the powerless.

The use of HRBAs challenges vested interest and power structures key to elimination of barriers to the enjoyment of sexual and reproductive health rights. Critics of HRBAs draw attention to the role of public – private partnerships which play a rather an

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152 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 67.  
157 Ibid.  
158 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 68.
important role in the enjoyment of the right to health particularly in Africa and argue that:

... Human rights assumes a dyadic relationship of the citizen as claims holder and the government as duty bearer. But this is a mistake, especially in a context such as East Africa where so many of the parameters for people being able to enjoy their health rights, including in relation to sexual and reproductive health, are determined by non-state actors and actors beyond borders. In the current development context, which appears to favour public – private partnerships and the role of private investment as well as philanthropy in development, HRBAs need to be especially attuned to the participation and the role of donors and other non-state actors in shaping health policies and programmes, as well as to the broader economic contexts of especially heavily aid-dependent countries. Yet these norms are not to date especially well-developed in international law.\(^\text{159}\)

Equally, Gruskin et al., has critiqued the UN for its ‘Common Understanding’, which they describe as the ‘lowest common denominator approach’ for it ‘privileges consensus over specificity’.\(^\text{160}\) Its general nature, Gruskin and others argue, has made it difficult to operationalise instead resulted in different agencies e.g. UNDP, UNFPA and UNICEF taking different aspects of common understanding reflecting their mandate.\(^\text{161}\)

While the thesis recognises the dead-ends human rights can lead to and the challenges to human rights-based approach,\(^\text{162}\) it emphasises that human rights have the potential to make gains for sex workers (a vulnerable and marginalised group) as right-holders for the enjoyment of their sexual and reproductive health rights in Kenya.

\section*{2.2 Feminist Legal Theory}

Feminist legal theory plays an important role outlining the intersection between law and gender.\(^\text{163}\) It examines issues that affect women and offers a framework within which to expand the notion of human rights to include those rights that affect primarily women.\(^\text{164}\) Ambreena Manji contends that women and men perceive the boundaries of

\(^{159}\) Yamin and Cantor, ‘Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health’ (n 46) 476.

\(^{160}\) Gruskin et al., ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities and Assessment’ (n 23) 134.

\(^{161}\) Ibid.


law differently and that the law has to be scrutinised. Women are affected differently especially, Manji notes, when legislation was enacted to control them especially in the global south. Although, not all sex workers around the globe are women, arguably, women remain historically the majority in sex work as noted in chapter one. The feminist rhetoric around sex work remains highly focused on the female sex workers.

Sex work in the Kenyan and much of the African context is highly stigmatised and the women who provide the sexual services are often the subjects of discrimination. While the biological differences between women and men in matters of their sexual and reproductive health should be taken note of, discrimination against women is closely associated with prejudices and stereotypes based on patriarchal notions of women’s sexual and reproductive roles and functions, argues Kamala Kempadoo. Feminist legal theory exposes male bias and brings women’s experiences into discussion. For example as illuminated in chapter one, the law on sex workers in Kenya seems to target both female and male sex workers, yet in reality it focuses more on the female sex workers who are often arrested by police.

According to Martha Fineman, ‘feminists are concerned with the implications of historic and contemporary exploitation of women within society, seeking the empowerment of women and the transformation of institutions dominated by men.’ Although feminism offers as Moghadam noted, ‘a form of analysis and a critique of women’s positions and of society as a whole and a goal to effect social change through improvements in the legal status and social positions of women,’ feminism is not a

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166 Ibid 445.


171 Kim, ‘Toward a Feminist Theory of Human Rights: Straddling the Fence Between Western Imperialism and Uncritical Absolutism’ (n 164).


monolithic discourse, asserts Chowdhury.\textsuperscript{175} Feminist scholars aver that it comprises of considerable ‘historical’ and ‘ideological’ differences.\textsuperscript{176} These differences have helped feminists understand their gender oppression.\textsuperscript{177} Arguably, even with a general acceptance that women are oppressed, women do not agree on their sources of oppression nor do they share their views on how to terminate their oppression.\textsuperscript{178} Bell Hooks remarks that ‘just as our lives are not fixed or static but always changing, our theory [feminist] must remain fluid, open, responsive to new information.’\textsuperscript{179} To be a feminist is to always pose the question: ‘What about women?’\textsuperscript{180} The ‘woman question’ as Hilaire Barnett has written in her \textit{Introduction to Feminist Jurisprudence}, ‘demands explanations for women’s exclusion from all areas of life: it demands justification from those who perpetuate women’s exclusion.’\textsuperscript{181} Barnett articulates that, the woman question asks:

\begin{quote}
\textit{[W]}hy is it that despite more or less equal employment opportunities, it is still women who undertake the child-rearing and domestic responsibilities within the home? It asks, in relation to medical issues, by what right the law prohibits or limits abortion against a woman’s wishes; or sanctions sterilisation of women without their consent ... The woman question also asks how politicians, in their role of law makers, constructs the image of woman in the law.\textsuperscript{182}
\end{quote}

Some men, as scholars argue, have advocated for women’s cause.\textsuperscript{183} Feminism, they contend, is to be at odds with male-dominated culture and society.\textsuperscript{184} Chimamanda Adichie defines a feminist as ‘a man or a woman who says, ‘yes there’s a problem with gender as it is today and we must fix it, we must do better.’\textsuperscript{185} Karen Offen sets out the three criteria for one to be considered a feminist.

\begin{quote}
They recognise the validity of women’s own interpretations of their lived experience and needs and acknowledge the values women claim publicly as their own (as distinct from an aesthetic ideal of womanhood invented by men); they exhibit consciousness of, discomfort at, or even anger over institutionalised injustice (or inequity) toward
\end{quote}

\begin{flushright}
\textsuperscript{176} Ibid.
\textsuperscript{178} Ibid.
\textsuperscript{180} K Offen, ‘Defining Feminism: A Comparative Historical Approach’ (1988) 14:1 Signs 119.
\textsuperscript{182} Ibid.
\textsuperscript{183} Offen, ‘Defining Feminism: A Comparative Historical Approach’ (n 180) 151.
\textsuperscript{184} Ibid 152.
\textsuperscript{185} CN Adichie, \textit{We Should All Be Feminists} (Fourth Estate 2014) 48.
\end{flushright}
women as a group by men as a group in a given society; and they advocate the elimination of that injustice by challenging, through efforts to alter prevailing ideas and/or social institutions and practices, the coercive power, force, or authority that upholds male prerogatives in that particular culture.\textsuperscript{186}

Then again, some feminism supporters refute the ‘feminist’ label. They feel embarrassed to use the word ‘feminist’\textsuperscript{187} and questions have even been asked whether feminism is relevant to Africa for example.\textsuperscript{188} While feminism is not new or strange in Africa, the word ‘feminist’ is heavily weighted with negative baggage including the hate for men, the hate for African culture, and being angry, comments Adichie.\textsuperscript{189} In terms of ‘culture’ for example, Adichie holds that ‘culture does not make people. People make culture’ and insists that ‘if it is true that the full humanity of women is not our culture, then we can and must make it our culture.’\textsuperscript{190} Kolawole states that while addressing gender in Africa, it is fundamental to put into perspective its historical and cultural contexts.\textsuperscript{191} To define feminism within gender discrimination is narrow and insufficient to redress the oppression of women in the global south.\textsuperscript{192} Johnson-Odim observes that the narrow definition has led to other feminists not to use the term ‘feminist’.\textsuperscript{193} It is argued that gender discrimination is not the primary neither is it the sole focus of the oppression of women in the global south.\textsuperscript{194}

According to Ratna Kapur, while indeed it is agreed that women have struggled as victims to subvert power, the power women have struggled to subvert does not emanate from a single source, that is, men.\textsuperscript{195} For example resistance to the colonial encounter was central to the experience of subordination of women in India\textsuperscript{196} and much of the global south. The colonial history cannot, Kapur argues, be understood in terms of the ‘history of gender subordination or sexual violence perpetrated by men against women.’

\textsuperscript{186} Offen, ‘Defining Feminism: A Comparative Historical Approach’ (n 180) 152. 
\textsuperscript{188} Ibid 221-222. 
\textsuperscript{189} CN Adichie, We Should All Be Feminists (Fourth Estate 2014) 11. 
\textsuperscript{190} Ibid 46. 
\textsuperscript{191} MD Kolawole, ‘Transcending Incongruities: Rethinking Feminism and the Dynamics of Identity in Africa’ (2002) 17:54 Agenda: Empowering Women for Gender Equity 92. 
\textsuperscript{192} C Johnson-Odim, ‘Common Themes, Different Contexts: Third World Women and Feminism’ in CT Mohanty, A Russo and L Torres (eds), Third World Women and the Politics of Feminism (Indiana University Press 1991) 314, 315. 
\textsuperscript{193} Ibid. 
\textsuperscript{194} Ibid. 
\textsuperscript{196} Ibid.
Kapur further argues that it was also about the ‘broader economic and political subordination and expropriation of another nation’s labour, resources, land, raw materials and market and the exclusion of the native – both men and women – from sovereignty and legal entitlements.’

According to Kolawole ‘Womanism’ hence ‘Womanist’ as defined by Alice Walker accommodates African women’s reality. Walker says ‘womanist is to feminist as purple is to lavender’ and defines ‘Womanist’ as a:

Black feminist or feminist of colour who loves other women and/or men sexually and/or nonsexually, appreciates and prefers women’s culture, women’s emotional flexibility and women’s strength and is committed to survival and wholeness of entire people, male and female.

Alice Walker coined the term ‘Womanist’, Molara Ogundipe-Leslie ‘Stiwanist’, while Obioma Nnaemeka ‘nego-feminist’. Ogundipe-Leslie advocates for ‘Stiwanism’ coming from the term ‘Stiwa’ (Social Transformation Including Women in Africa) which in her view connotes inclusion of African women in the contemporary social and political transformation of Africa and would avoid many accusations of imitating Western feminism. On the other hand, Nnaemeka argues that feminism in Africa is challenged through ‘negotiation, accommodation and compromise’ thus ‘nego-feminism’.

Amina Mama points out in ‘Talking about Feminism in Africa’ that changing the terminology does not get away from the main problem. She contends that ‘western feminists have agreed with much of what we have told them about different women being oppressed differently, and the importance of class and race and culture in

197 Ibid.
198 Ibid.
199 Kolawole, ‘Transcending Incongruities: Rethinking Feminism and the Dynamics of Identity in Africa’ (n 190).
201 Ibid xi.
202 Ibid xi.
configuring gender relations\textsuperscript{208} and asks, ‘having won that battle why would we want to abandon the struggle, leave the semantic territory to others, and find ourselves a new word?’\textsuperscript{209} Mama eloquently declares that:

\begin{quote}
I have never felt offended by being addressed as a feminist, but rather humbled and daunted at the responsibility it bestows on me. Feminism remains positive, movement-based term, with which I am happy to be identified. It signals a refusal of oppression, and a commitment to struggling for women’s liberation from all forms of oppression – internal, external, psychological and emotional, socio-economic, political and philosophical.\textsuperscript{210}
\end{quote}

The women’s struggle recognises that patriarchal control has direct impact on sexual and reproductive health decision-making\textsuperscript{211} and that women’s rights more so sexual and reproductive health rights cannot be attained without women’s empowerment and gender equality\textsuperscript{212} especially in the global south. According to Burrows, women’s rights are not rights which are specific to women, these are universally recognised rights held by all people by virtue of their common humanity.\textsuperscript{213} Women’s rights are indivisible and interdependent. Whatever their inadequacies, feminist scholars argue, rights rhetoric has been the vocabulary most effective for analysing mass progressive movements and can empower subordinate groups to challenge the forces that perpetuate their subordination.\textsuperscript{214} Equally, scholars caution that cultural relativism is a highly effective weapon for attacking women’s human rights and by labelling women’s human rights as a post colonialist imposition they argue that women’s enemies succeed to isolate and undermine them.\textsuperscript{215} The situation is complex if these rights are associated with sex workers.

Sex work is a contentious issue in feminism. On one side, as Stéphanie Wahab and Meg Panichelli observe are liberal feminist who emphasise the importance of sex workers’

\begin{footnotes}
\item[208] Ibid 61.
\item[209] Ibid.
\item[210] Ibid 59.
\item[211] VK Pillai and Guang-Zhen Wang, *Women’s Reproductive Rights in Developing Countries* (Ashgate 1999) 53.
\item[212] Ibid 36.
\end{footnotes}
rights and understand sex work as potentially ‘liberating and empowering’. On the other side are radical feminist who believe sex work is exploitative, casting sex workers as coerced victims and frame sex workers as unable to participate in research about their ‘lived realities’. According to this strand of feminist, sex workers are only ever victims of male violence and sexual exploitation. Under those circumstances, it is argued that little regard is given for the complexity and diversity of sex worker experiences, opinions and perspectives. In particular scholars have warned radical feminists of the dangers of making alliances with conservative forces resulting into stringent laws which discourage sex workers from reporting violence, domestic abuse, rape or other human rights abuse increasing their vulnerability.

The thesis uses transnational feminist theory to build onto postcolonial feminism to offer a deeper and informed reflection in postcolonial and transnational feminist debate and to argue that ‘objectification’ and ‘victimisation’ of sex workers in Kenya invalidates their voices and denies them the agency and self-determination to make their own sexual and reproductive health decisions. I explore the local and global dimensions of the struggles of sex workers particularly when domestic laws that impact on their sexual and reproductive health rights are increasingly influenced by regional and international human rights principles including court decisions.

Postcolonial feminists are concerned in particular with hegemonies of Western feminist scholarship. These feminists confront the way Western feminists depict ‘Third World women and sex workers as victims’. They argue that Western feminism is characterized by a ‘liberal agenda’ that focuses on women’s rights and equality within the context of capitalist societies. In contrast, postcolonial feminists critique the dominant narratives of Western feminism and argue for a more inclusive and intersectional approach that takes into account the unique experiences and challenges faced by women in different cultural and historical contexts. They also advocate for a more democratic and participatory approach to feminist theory and practice.

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219 Ibid.
220 Ibid 380.
Woman’ as a singular monolithic subject. Mohanty argues that, women in third-world are objectified and constructed as homogenous groups and victims of cultural and socio-economic systems. Mohanty argues that the homogenisation constructs ‘the third world woman’ as one who ‘leads an essentially truncated life based on her feminine gender (read: sexually constrained) and being ‘third world’ (read: ignorant, poor, uneducated, tradition-bound, religious, domesticated, family-oriented, victimised, etc.). The postcolonial feminists argue that objectification of third world women has to be named and challenged. Valerie Amos and Pratibha Parmar assert that: ‘Feminist theories which examine our cultural practices as ‘feudal residues’ or label us ‘traditional’, also portray us as politically immature women who need to be versed and schooled in the ethos of Western feminism. They need to be continually challenged’.

Martha Nussbaum in her work ‘Objectification’ defines the term ‘objectification’ as ‘the seeing and/or treating someone as an object’. While postcolonial feminists are concerned with how women in the global south are treated by women in the West, this thesis is concerned with how the already objectified women are further objectified. Nussbaum sets out the following seven ways in which the objectifier can treat a person as a thing. That is instrumentality, denial of autonomy, inertness, fungibility, violability, ownership and denial of subjectivity. Instrumentality means a person is treated as a tool primarily for objectifier’s purposes and denial of autonomy, a person is treated as lacking in autonomy and self-determination. Inertness means a person is treated as lacking in agency perhaps also in activity and fungibility, a person is treated as interchangeable with similar or different objects. Violability includes the treatment of a person as lacking in boundary-integrity which can be handled in any manner and ownership, a person is treated like something that is owned by another and can be bought or sold. Finally, denial of subjectivity means the treatment of a person as something whose experience and feelings (if any) need not be taken into account.

227 Mohanty, ‘Under Western Eyes: Feminist Scholarship and Colonial Discourses’ (n 10) 66.
228 Ibid 65.
230 Amos and Parmar, ‘Challenging Imperial Feminism’ (n 229) 48-49.
232 Ibid 257.
While context in which objectification is conducted has to be put in mind, Nussbaum affirms that a person can be treated in one or many of these seven ways.\textsuperscript{233}

Third world sex workers have been construed as helpless victims in need of rescue and not human rights protection as sex workers.\textsuperscript{234} Scholars point out that some feminists have used this opportunity to further their own interests including supporting repressive measures in the name of protecting women from prostitution.\textsuperscript{235} Arguably, even the proponents of sex work often than not set up a dichotomy between ‘voluntary’ western sex workers and ‘victimised’ sex workers in the global south.\textsuperscript{236} Interestingly, Doezema suggests that to a third world feminist, ‘the suffering third world prostitute’ serves well to symbolise the excesses of the global march of capital, and its negative effects on women.\textsuperscript{237} In Doezema’s view, looking at women’s campaigns as imposed by western feminism, ignores the national and cultural context in which these campaigns are formed.\textsuperscript{238} In a way Mohanty extends this thinking in her work, “‘Under Western Eyes’ Revisited: Feminist Solidarity through Anti-capitalist Struggles’, which emphasises on the ‘the connections between the local and the universal.’\textsuperscript{239} Mohanty reiterates that, ‘differences are never just differences’.\textsuperscript{240} In knowing differences and particularities, Mohanty argues:

\begin{quote}
... we can better see the connections and commonalities because no border or boundary is ever complete or rigidly determining. The challenge is to see how differences allow us to explain the connections and border crossings better and more accurately, how specifying difference allows us to theorise universal concerns more fully. It is this intellectual move that allows for my concern for women of different communities and identities to build coalitions and solidarities across borders.\textsuperscript{241}
\end{quote}

The courts have been a major reference point in portraying culture and society in Kenya and exclusion of women. For example in a 1995 case of Beatrice Wanjiru Kimani v Evanson Kimani Njoroge,\textsuperscript{242} in the wake of decades of United Nations conferences on

\begin{flushleft}
233 Ibid.
235 Ibid 33.
236 Ibid 18.
237 Ibid.
238 Ibid.
240 Ibid.
241 Ibid.
\end{flushleft}
women, women received a backlash for going to Beijing to ‘look’ for an ‘ideology’. The court frowned upon women in Kenya for their participation in the enormous struggle for women’s rights in the 1995 United Nations Beijing Conference. Thus constructing the Kenyan women’s spaces for inclusion as spaces for defiance.

Many a married woman goes out to work. She has a profession. She has a high career. She is in big business. She travels to Beijing in search of ideologies and a basis for rebellion against her own culture. Like anyone else, she owns her own property separately, jointly or in common with anyone. Her business interest, her property and whatever is hers is everywhere in Kenya and abroad, in the rural, urban and outlying districts. In Nairobi alone her property and businesses, swell through Lavington, Muthaiga, Kileleshwa, Kenyatta Avenue, swirls in Eastlands, with confluents from everywhere. Perhaps apart from procreation and occasional cooking, a number of important wifely duties obligations and responsibilities are increasingly being placed on the shoulders of the servants, machines, kindergartens and other paid minders. Often the husband pays for all these and more...243

Despite critiques, feminist scholars have recognised the key role the UN has played in providing the women the platform to caucus and network and advance the struggle of women’s rights244 equally seen as a commitment to HRBAs.245 The Fourth World Conference on Women in Beijing in 1995 and other UN conferences in 1990s birthed ‘global feminism’ as Moghadam puts it.246 A major achievement of the 1994 International Conference on Population and Development for example, Jane Cottingham et al., argue, was recognition of the responsibility of governments to translate international commitments into national laws and policies that promote sexual and reproductive health rights.247 Significantly, the Beijing Conference articulated women’s rights as human rights.248 Global feminism is on the premise that ‘notwithstanding cultural, class, and ideological differences among women of the world, there is commonality in the forms of women’s disadvantage and the forms of women’s

243 Ibid.
245 Twomey, ‘Human Rights-Based Approaches to Development: Towards Accountability’ (n 22) 56.
organisations worldwide.’ Moghadam eloquently notes that, the Beijing Declaration and Platform for Action is the manifesto of global feminism as it states:

The objective of the Platform for Action, which is in full conformity with the purposes and principles of the Charter of the United Nations and international law, is the empowerment of all women. The full realisation of all human rights and fundamental freedoms of all women is essential for the empowerment of women. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms ... 

While ratification of international human rights instruments by countries in the global south does not eliminate all discrimination and bias against sex workers as an African feminist, I argue that invoking human rights bring to the fore sex workers struggles. The representative of Bar Hostess Empowerment and Support Programme said in this interview:

Sex workers come from all walks of life, from all over and use the day [International Sex Workers Day] to show visibility, to show the human face of sex workers, to lobby for the rights of sex workers, to join in community, to put it in the face of people who want to pretend that such things do not exist, but also to lobby the support and to remember sex workers who have been murdered, who have died in the line of duty, to celebrate the milestones we have achieved as a community and how far we have come.

2.3 Conclusion

This chapter has provided the theoretical underpinnings of the thesis. It has demonstrated the importance of the theoretical framework to sexual and reproductive health rights to better understand the role human rights and feminist perspective play to the lives of women and in particular sex workers in the global south and their situation in relation to law. It has shown that despite criticisms, human rights-based approaches to sexual and reproductive health rights of sex workers remain a significant framework that women in Africa and around the world employ in their daily struggles in the local,
national, regional and global justice.\textsuperscript{252} The next chapter critically analyses protections available in the international and regional legal frameworks as well as the Kenyan constitutional context.

\textsuperscript{252} Zwingel (n 8) 345.
Chapter Three

The International and Regional Legal Framework and the Constitution of Kenya in Context

... I have rights. People have to treat me like a human being ...\(^1\)

All human beings are born free and equal in dignity and rights.\(^2\)

3.0 Introduction

The two questions ‘to what extent have laws and policies adopted a rights-based approach?’ as well as ‘what are the mechanisms that promote or deny the enjoyment of sexual and reproductive health rights of sex workers?’ have both been answered in this chapter and in chapter five. This chapter is considered in two parts and provides analysis of international, regional and constitutional legal frameworks available to promote and protect sexual and reproductive health rights for sex workers in Kenya. The chapter examines the extent to which a human rights-based approach has actually developed in relation to sexual and reproductive health rights internationally and regionally and has then been adopted in Kenya. It explores the contribution of 2010 Constitution to this development and uses the international treaty reporting mechanisms as a means to test the extent of implementation. Chapter one has shown that Kenya has a strong record of ratifying major international and regional human rights instruments,\(^3\) and these are, according to the Constitution of Kenya 2010, part of its law.\(^4\) Human rights-based approaches are grounded in these international human rights treaties. As State party to these instruments Kenya has an obligation to ensure that the rights of women especially their right to the highest attainable standard of health including

\(^1\) Interview with Sex worker 7 (Nairobi, 15 July 2015).
\(^3\) Vienna Convention on the Law of Treaties 1969, Article 14 provides that as follows

3. The consent of a State to be bound by a treaty is expressed by ratification when:
   (e) the treaty provides for such consent to be expressed by means of ratification;
   (f) it is otherwise established that the negotiating States were agreed that ratification should be required;
   (g) the representative of the State has signed the treaty subject to ratification; or
   (h) the intention of the State to sign the treaty subject to ratification appears from the full powers of its representative or was expressed during the negotiation.

4. The consent of a State to be bound by a treaty is expressed by acceptance or approval under conditions similar to those which apply to ratifications.

See Appendix A: Selected International and Regional Treaties Ratified by Kenya.

\(^4\) Constitution of Kenya 2010, Article 2(5) and (6).
sexual and reproductive health rights e.g. non-discrimination and the right to information throughout the country are respected, protected and fulfilled.\(^5\)

The chapter begins with the analysis of non-binding International Conference on Population and Development (ICPD) in Cairo in 1994 and the 1995 Fourth World Conference on Women in Beijing yet of critical importance to policy in Kenya. The two United Nations Conferences linked gender equality and women and girls’ health including sexual and reproductive health\(^6\)\(^7\) making them usable by sex workers. The rest of the chapter takes the form of two parts. Part one critically examines the international and regional human rights framework. It focuses on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),\(^8\) the International Covenant on Economic, Social and Cultural Rights (ICESCR)\(^9\) and lastly, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the ‘Maputo Protocol’).\(^10\) The chapter considers these three international and regional human rights treaties due to their advancement of non-discrimination and the removal of economic, social and cultural barriers which contribute to women such as sex workers being vulnerable to sexual and reproductive health abuse. Despite their universal focus on human rights, CEDAW and the Maputo Protocol are politically woman-centred.\(^11\)

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Protocol is equally a unique feature of the African normative human rights framework and underscores African women’s lead in developing an international framework. Part two of this chapter investigates the Constitution of Kenya (2010). Prior to the 2010 Constitution, the court in Kenya held in *Okunda v Republic*\(^{13}\) that international law is not a source of law in Kenya. Subsequently, in the High Court case *Re The Matter of Zipporah Wambui Mathara*,\(^{14}\) the court held that by virtue of Article 2(6) of the Constitution of Kenya (2010), international treaties and conventions that Kenya had ratified, were imported as part of the sources of Kenyan law.\(^{15}\) The chapter critically examines the protections afforded by sexual and reproductive health rights to women and especially marginalised women such as sex workers under the Kenyan Constitution to provide a detailed account of the potential impact of the Constitution to the enjoyment of sexual and reproductive health rights by sex workers in Kenya.

Hence, in section 3.1, the chapter explores the Cairo Programme of Action and the Beijing Declaration and Platform for Action, in section 3.2 international and regional legal frameworks, in particular reviewing the protections under section 3.2.1 on the right to non-discrimination and equality (in section 3.2.1.1), protection against gender-based violence (in section 3.2.1.2), the freedom from exploitation of sex workers (in section 3.2.1.3), the right to health including sexual and reproductive health (in section 3.2.1.4) and the Right to Information (in section 3.2.1.5). Section 3.2.2 examines the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa and the reservations of the Kenyan government. Section 3.3 interrogates the constitutional legal framework and different health and human-rights related rights.


\(^{13}\) [1970] EA 512 the court held that ‘...the provisions of a treaty entered into by the government of Kenya do not become part of the municipal law of Kenya save in so far as they are made such by the law of Kenya. If the provisions of any treaty, having been made part of the municipal law of Kenya, are in conflict with the constitution, then, to the extent of such conflict, such provisions are void.’

\(^{14}\) [2010] High Court of Kenya at Nairobi Bankruptcy Cause No 19 of 2010 (eKLR).

\(^{15}\) Ibid, para 9; Subsequently in the case of *Beatrice Wanjiku & Another v Attorney General & Another* [2012] [17], the court stated that: ‘Before the promulgation of the Constitution, Kenya took a dualist approach to the application of the international law. A treaty or international convention which Kenya has ratified would only apply nationally if Parliament domesticated the particular treaty or convention by passing the relevant legislation. The Constitution and in particular Article 2(5) and 2(6) gave new colour to the relationship between international law and international instruments and national law.’ See CEDAW Committee, Concluding Observations: Kenya UN Doc CEDAW/C/KEN/8 (2016), the government of Kenya states in para 8 that: ‘Section 2(6) of the Constitution of Kenya provides for the domestication and applicability of CEDAW provisions by providing that any treaty or convention ratified by Kenya shall form part of the law of Kenya under the Constitution’.
including the right to non-discrimination and equality (in section 3.3.1) and the right to health including sexual and reproductive health (in section 3.3). Finally, the chapter draws key conclusions (in section 3.4).

3.1 The Cairo Programme of Action and the Beijing Declaration and Platform for Action

The 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing are significant United Nations conferences for building on WHO’s definition on health,\(^{16}\) stipulated in its 1948 Constitution as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’\(^{17}\) Of importance, the documents that emanated from these two United Nations Conferences in the 1990s strongly assert and support sexual and reproductive health concepts.\(^{18}\) For example, the Committee on the Elimination of Discrimination against Women pointed out for Kenyan government to use the Beijing Declaration and Platform for Action to implement CEDAW.\(^{19}\) In particular, the 1994 United Nations International Conference on Population and Development played an instrumental role in raising awareness of women’s right to health among governments in the world, especially in Africa.\(^{20}\) The ICPD programme of Action is framed within human rights based understanding of reproductive health rights.\(^{21}\) It shifted the focus of countries in the global north and global south from a demographic perspective to an emphasis on the rights and needs of individuals,\(^{22}\) including female sex workers.

The Programme of Action for the ICPD was adopted by Kenya along with other 178 countries including Uganda, Nigeria, Zambia, Zimbabwe, South Africa, Malawi in

\(^{16}\)Cook and Fathalla, ‘Advancing Reproductive Rights Beyond Cairo and Beijing’ (n 7)
\(^{17}\)The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 and entered into force on 7 April 1948.
\(^{19}\)CEDAW Committee, Concluding Observations: Kenya UN Doc. CEDAW/C/KEN/CO/8, para 53.
Africa. A focus was put on empowering women and protecting their human rights, including sexual and reproductive health rights. The Cairo Programme of Action defined reproductive health as:

... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The ICPD Programme of Action defines ‘reproductive rights’ as embracing ‘certain human rights that are already recognised in national laws, international human rights documents and other consensus documents.’ These rights, it states, ‘rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.’

24 Cook and Fathalla, ‘Advancing Reproductive Rights Beyond Cairo and Beijing’ (n 7) 73 and 74.
26 Ibid para 7.3. See also Principle 8 states that:

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

27 Ibid para 7.3.
Sexual health was defined as part of reproductive health above. However, World Health Organisation has developed the concept of sexual health.\(^{28}\) In spite of the differences between sexual and reproductive health, Ebenezer Durojaye echoes that they are interrelated and complement each other.\(^{29}\) WHO defines sexual health as:

\[
\ldots \text{a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.}\(^{30}\)
\]

Rebecca Cook and Mahmoud Fathalla, emphasise the lack of enforcement mechanisms in the Cairo Platform for Action and the Beijing Declaration and Platform for Action.\(^{31}\) While it is argued that the Beijing Declaration and Platform for Action reaffirms the Cairo Programme of Action’s definition of reproductive health, it is hailed for further advancing the focus on women.

\[
The \text{human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.}\(^{32}\)
\]

The Beijing Declaration and Platform for Action further recognises the highest attainable standard of sexual and reproductive health for women by defining reproductive healthcare as:

\[
\ldots \text{the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.}\(^{33}\)
\]


\(^{29}\) Ibid.


\(^{31}\) Cook and Fathalla, ‘Advancing Reproductive Rights Beyond Cairo and Beijing’ (n 7) 74.


\(^{33}\) Ibid para 94.
However, the ability to hold the Kenyan government accountable is found in its local laws examined in chapter five, the 2010 Constitution and international human rights treaties, discussed below. A treaty is defined by the Vienna Convention on the Law of Treaties as ‘an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation.’ Commitment to human rights treaties means that:

... the realisation of human rights becomes an interest in itself. States parties to human rights treaties not only are obliged not to violate human rights but also to contribute to political and socio-economic conditions favourable to respect, protect, and fulfil human rights on the national and international level.

International human rights law provides well-established legal frameworks for sexual and reproductive health rights, and Kenya as a State party to CEDAW, ICESCR and the Maputo Protocol has an obligation to ensure that sexual and reproductive health rights are progressively translated into practice.

3.2 The International and Regional Legal Frameworks

As already noted in chapter one, the right to sexual and reproductive health intersects with many other rights, such as the rights to life, to non-discrimination, to dignity, to equality and to liberty enshrined in CEDAW, ICESCR and the Maputo Protocol. For Charles Ngwena and others, the civil and political rights components of sexual and reproductive rights cannot be separated from the socio-economic components. These international human instruments are legally binding and reassert a commitment to the rights laid out in the 1948 Universal Declaration of Human Rights; Navanethem

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Pillay, then High Commissioner for Human Rights, stated that ‘an extensive and growing corpus of international law has fleshed out the Universal Declaration’s principles, specifying States’ obligations in upholding them. They have found an echo globally in constitutions and national laws.’ They impose on the government of Kenya an obligation to respect, protect, and fulfil sex workers’ sexual and reproductive health rights. While in an ideal world these legal norms would be observed, in reality they are not, notes Carmel Shalev.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the United Nations General Assembly, entered into force on 3 September 1981 and has been ratified by 189 countries, including by Kenya on 9 March 1984, just prior to it hosting the 1985 Third World Conference on Women in Nairobi. It consists of a preamble and 30 articles and constitutes over 90 per cent of United Nations Members as party members. Adopted more than a decade earlier in 1966, the International Covenant on Economic, Social and Cultural Rights (ICESCR) entered into force on 3 January 1976 and has been ratified by 165 countries, including Kenya on 1 May 1972. In the region, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa was adopted on 11 July 2003, in Maputo, Mozambique, and came into force on 25 November 2005, upon 15 ratifications from Member States of the African Union; it primarily advances the rights of women.

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42 Shalev, ‘Rights to Sexual and Reproductive Health: The ICPD and the Convention on the Elimination of All Forms of Discrimination against Women’ (n 6) 43 and 49.
43 Ibid 49.
and girls in Africa. Like CEDAW, Kenya ratified the African women’s Protocol in October 2010, prior to hosting the launch of the Africa Women’s Decade in Nairobi in the same month, with the theme of a ‘Grassroots Approach to Gender Equality and Women’s Empowerment’, with ‘health’ as one of its ten thematic areas. The Maputo Protocol stems from the fact the African Charter did not adequately address the rights of women across the continent. The African Charter mentions the word ‘women’ once and even then, as Joe Oloka-Onyango argues, it was only in an omnibus clause dealing with the family and children, thus it is insensitive to the plight of women in Africa. Studies further indicate that the African Charter is generally silent on African women’s rights, especially sexual and reproductive health rights. However, in spirit, it aligns itself with ICPD, CEDAW, ICESCR and other treaties, as Article 18(3) of the African


Charter requires State parties to ‘ensure the elimination of every discrimination against women and also ensure the protection of the rights of women and the child as stipulated in international declarations and conventions.’ 55 Thus, the Maputo Protocol complements the African Charter. 56 It specifically aims to ensure that state parties, including Kenya, provide adequate protection for women and their human rights in Africa, 57 including sex workers.

Although the implementation of CEDAW and the Maputo Protocol falls within the remit of the Ministry of Public Service, Youth and Gender Affairs in Kenya, and ICESCR under the Office of the Attorney General and Department of Justice, a multi-sectoral approach, as underscored in chapter two, is key to achieving effective implementation of a human rights-based approach to sexual and reproductive health rights, as enshrined in CEDAW, ICESCR and the Maputo Protocol. It involves different government ministries and other government and non-governmental actors, including women who work in transnational activist networks, 58 such as the Kenya Sex Workers Alliance (KESWA) and the Bar Hostess Empowerment and Support Programme (BHESP). 59 It is worthwhile noting here that, for the first time ever sex workers in Kenya submitted a shadow report to the 68th Session of the CEDAW Committee. The report titled ‘Aren’t We Also Women?’, not only draws the attention of the CEDAW committee to the violence, stigma and criminalisation affecting sex workers, including...
trafficking and the criminalisation of HIV in Kenya, but also, I argue, challenges CEDAW on whether some women are better than others in terms of rights. In particular this is a statement to sex workers’ resistance to subordination and being excluded from access to human rights.

3.2.1 Fulfilling Human Rights Principles and Standards of Sexual and Reproductive Health Rights

When discrimination and inequality is eliminated sex workers like everyone else would enjoy sexual and reproductive health guarantees provided in the international human rights law. The impact in different aspects of their lives would be significant. In this section, I argue that countries in the global south Kenya in particular have to take their international and regional obligations seriously and deal with gender-based violence, lack of information and other concerns that stop women including sex workers from fully enjoying their sexual and reproductive health rights.

3.2.1.1 The Right to Non-Discrimination and Equality

Non-Discrimination is a basic principle of human rights. By ratifying international and regional human rights treaties, Kenya assumes the duty to eliminate discrimination against women, including female sex workers, in all civil, political, economic, social and cultural areas. CEDAW consists of 30 Articles and specifically focuses on the rights of women and girls, while the ICESCR contains 31 Articles and promotes and protects the rights of all people, including women who are sex workers. In her work ‘Feminist Influences on the United Nations Human Rights Treaty Bodies’, Rachael Johnstone questions whether international human rights law, with its limited enforcement, offers any advancement to women. She argues that while ICESCR guarantees the enjoyment of equal rights for men and women, CEDAW promised to eliminate any discrimination against women; however, inequalities persist and,

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fundamentally, nothing much has changed.\textsuperscript{65} Darren Rosenblum critiques CEDAW for its failure to define its central subject, ‘women’.\textsuperscript{66} He further holds that CEDAW cannot achieve equality for the reason that it is ‘narrow and exclusively focused’.\textsuperscript{67} According to Rosenblum, the Convention excludes women who are victims as well as men, and other sexes.\textsuperscript{68}

In its Preamble, CEDAW articulates that:

... discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life in their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the services of their countries and of humanity.\textsuperscript{69}

Women’s Convention came into force as a response to the perception of women that other international human rights instruments had failed to deal effectively with women’s rights.\textsuperscript{70} Nonetheless, despite its implementation challenges, CEDAW, sometimes referred to as the international bill of women’s rights, remains the central pillar of gender equality norms at the international level.\textsuperscript{71} It protects and promotes the right of every woman to non-discriminatory health\textsuperscript{72} and defines discrimination against women as:

... any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.\textsuperscript{73}

Discrimination is a violation of CEDAW and ICESCR and other international human rights instruments. Article 2 of ICESCR calls upon the Kenyan government to respect and ensure the rights of women including sex workers, without discrimination of any

\textsuperscript{65} Ibid.
\textsuperscript{66} Rosenblum, ‘Unsex CEDAW, or What’s wrong with Women’s Rights’ (n 58) 124.
\textsuperscript{67} Ibid 100 and 105.
\textsuperscript{68} Ibid.
\textsuperscript{69} CEDAW, The Preamble.
\textsuperscript{73} CEDAW, Article 1.
kind, while Article 3 guarantees equal rights of men and women to the enjoyment of all economic, social and cultural rights under the Covenant. Article 2(1) of the ICESCR mandates progressive realisation to achieve the rights to sexual and reproductive health. ICESCR requires the Kenyan government to ‘...take steps individually and through international assistance and co-operation, especially economic and technical to the maximum of its available resources...’

CEDAW is directed at both public and private discrimination against women. Article 2 of CEDAW requires state parties including the Kenyan government to ‘condemn discrimination against women [including sex workers] in all its forms’ and ‘to pursue by all appropriate means and without delay a policy of eliminating discrimination against women’. The provision deals with women’s rights in the public sphere and recognised as one of the articles subject to majority reservations of CEDAW. Article 3 requires State parties to:

   ... take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

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74 ICESCR, Article 2(2) stipulates that: The State parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

75 Ibid Article 3.

76 Ibid Article 2(1).

77 Evatt, ‘The Early Days of CEDAW’ (n 70).

78 CEDAW, Article 2
   (a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realisation of this principle;
   (b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;
   (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;
   (d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institution shall act in conformity with this obligation;
   (e) To take all appropriate measures to eliminate discrimination against women by person, organisation or enterprise;
   (f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;
   (g) To repeal all national penal provisions which constitute discrimination against women.

79 J Riddle, ‘Making CEDAW Universal’ (2002) 24 George Washington International Law Review 605, 620; See Article 28(2) of CEDAW under which reservations are not permitted if they are incompatible with the purpose of the Convention.

80 CEDAW, Article 3.
In its review of Kenya’s report, the CEDAW Committee was concerned with the lack of comprehensive anti-discrimination legislation in Kenya and pointed to the absence of clear and complete protection against intersectional discrimination in Kenya’s Constitution.\(^\text{81}\) The CESCR Committee was equally concerned with the absence of comprehensive anti-discrimination legislation in compliance with Article 2 of ICESCR,\(^\text{82}\) including the failure of the government to comply with many court rulings.\(^\text{83}\) The committee urged the Kenyan government to adopt a comprehensive anti-discrimination law affording protection to all women, including lesbian, bisexual, transgender and intersex women.\(^\text{84}\)

### 3.2.1.2 Protection against Gender-based Violence

Despite its definition of discrimination as seen above and highlighting the public and private divide affecting women, CEDAW was criticised for not addressing gender-based violence against women.\(^\text{85}\) The gap was later filled with the consensus adoption by the General Assembly of the Declaration on the Elimination of Violence against Women in 1993. The violence aimed at women needed to be acknowledged and addressed by State parties, particularly on the role it played in holding women back from enjoyment of their Convention rights whether carried out by the state officials (the ‘public’ sphere) or non-state actors (the ‘private’ sphere).\(^\text{86}\) States should take responsibility to protect women including sex workers from the perpetrators of violence whether family or community members and not allow religion, family or culture to be used as an excuse for such abuse.\(^\text{87}\) I argue that lack of action provides an enabling environment for abuse against women particularly sex workers to thrive.

The Declaration on the Elimination of Violence against Women (1993) entitle women to the equal enjoyment and protection of all human rights including fundamental freedoms in the political, economic, social, cultural, civil or any other field.\(^\text{88}\) These

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\(^\text{82}\) CESCR Committee, Concluding Observations: Kenya UN Doc E/C.12/KEN/CO/2-5, para 19.

\(^\text{83}\) Ibid para 5.

\(^\text{84}\) CEDAW Committee, Concluding Observations: Kenya CEDAW/C/KEN/CO/8 (n 81), para 11.

\(^\text{85}\) C Chinkin, S Wright and H Charlesworth, ‘Feminist Approaches to International Law: Reflections from another Century’ in D Buss and A Manji (eds), International Law: Modern Feminist Approaches (Hart 2005) 17, 22.

\(^\text{86}\) Ibid.


\(^\text{88}\) Declaration on the Elimination of Violence against Women 1993 UN Doc A/RES/48/104, Article 3.
include set of rights such as: right to life, equality, liberty and security of person, equal protection under the law, free from all forms of discrimination, to the highest standard attainable of physical and mental health including sexual and reproductive health just and favourable conditions of work, and not to be subjected to torture, or other cruel, inhuman or degrading treatment or punishment. The Declaration acknowledges the role of the women movements in its Preamble and particularly in bringing issue of violence against women to light more so drawing increasing attention to the nature, severity and magnitude of the problem. The Declaration defines violence against women as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.’ It recognises violence against women perpetrated by the family, community and the state. The Declaration requires State parties to CEDAW to prevent, investigate, punish acts of violence and protect women from victimisation.

Violence is linked to a host of different short and long-term health outcomes. Sadly, many women do not report sexual violence e.g. rape, including coerced contact between the mouth and penis, vulva or anus to police because they are ashamed, or fear being blamed, not believed or otherwise mistreated. Studies show that a history of being the target of violence puts women at increased risk of sexual and reproductive health consequences such as infertility, pelvic inflammatory disease, pregnancy complications/miscarriage, sexual dysfunction, sexually transmitted infections, including HIV/AIDS, unsafe abortion, and unwanted pregnancy. Studies reveal that most abused women are not passive victims but rather adopt active strategies to maximise their safety and that of their children. Some women resist, others flee, while

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89 Ibid Articles 3(a) - 3(h).
90 Ibid Article 3(h)
91 Ibid Article 1.
92 Ibid Articles 2(a) - 2(c).
93 Ibid Articles 4(c) and 4(f).
94 R Jewkes, P Sen and C Garcia-Moreno, ‘Violence by Intimate Partners’ in E Krug, LL Dahlberg, JA Mercy, AB Zwi and R Lozano (eds), World Report on Violence and Health (World Health Organisation 2002) 147, 150 defines sex violence as ‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.’
still others attempt to keep the peace by giving in to their partners’ demands. Living in a violent relationship affects a woman’s sense of self-esteem and her ability to participate in the world. Studies indicate that abused women are routinely restricted in the way they can gain access to information and services, take part in public life, and receive emotional support from friends and relatives. Not surprisingly, such women are often unable properly to look after themselves and their children or to pursue jobs and careers.96

The CEDAW Committee recognises gender-based violence against women as a ‘fundamental social, political and economic means by which the subordinate position of women with respect to men and their stereotyped roles are perpetuated’ and that it is a ‘critical obstacle to the achievement of substantive equality between women and men and to the enjoyment by women of their human rights and fundamental freedoms under the Convention.’97 As of December 2017, the CEDAW Committee had adopted 36 general recommendations.98 General Recommendation No. 35 on Gender-Based Violence against Women (2017) lays emphasis on the elimination of all forms of violence against all women and girls in the public and private spheres. In its Concluding Observations, CEDAW Committee has urged the Kenyan government to strictly enforce its law on domestic violence i.e. the Protection against Domestic Violence Act 2015 and in so doing ensure that adequate human and financial resources are allocated; increase the investigation, prosecution and conviction rates for sexual and gender-based violence cases throughout the country; ensure there are no charges for the Kenya Police Medical Report Forms (P3 Form – produced by police in court as evidence of violence) for victims and disadvantaged groups of women (e.g. sex workers); adequate shelters are provided and that the judiciary, prosecutors and the police are adequately trained in gender-based violence cases against women and girls.99

96 Ibid 100.
97 CEDAW Committee, General recommendation No. 35 on Gender-Based Violence against Women UN Doc CEDAW/C/GC/35, para 10.
99 Committee on the Elimination of Discrimination against Women, Concluding Observations Kenya CEDAW/C/KEN/CO/8 (Advanced Unedited Version), para 23(a)-(e); See also CEDAW Committee, General Recommendation No 35 on Gender-Based Violence against Women UN Doc CEDAW/C/GC/35.
Inasmuch as CEDAW Committee acknowledged Kenya’s adoption of the 2015 Protection against Domestic Violence Act, the Committee was particularly concerned with the lack of enforcement and the prevalence of domestic violence, particularly against women, including the lack of reporting for a majority of domestic violence cases.\(^\text{100}\) The CEDAW Committee equally raised its concern on the plight of women in informal settlements such as the majority of sex workers interviewed in this study:

... high level of gender-based violence against women and girls, and widespread incidents of sexual violence, including rape, in both the private and public spheres, underreporting by victims, due to, inter alia, law enforcement and medical staff illegally charging victims for reporting forms, especially for disadvantaged groups of women and women in informal settlements, as well as the low prosecution rate in relation to gender-based violence against women.\(^\text{101}\)

### 3.2.1.3 Freedom from Exploitation for Sex Workers

Article 6 of CEDAW requires state parties to tackle trafficking and the exploitation of prostitution by taking ‘all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.’\(^\text{102}\) Rosenblum argues that CEDAW’s reference to prostitution robs women of agency and creates a victim-subject.\(^\text{103}\) He argues that not acknowledging the right of women to work as prostitutes denotes all prostitution as exploitative and sex workers as females in need of protection from their exploiters.\(^\text{104}\)

Cheryl Overs and Bebe Loff have an issue with the language used in CEDAW, such as ‘traffic in women’ and ‘exploitation of prostitution of women’, which, they argue, contributes to confusion in its implementation.\(^\text{105}\) It does not define the term ‘exploitation of prostitution’.\(^\text{106}\) Therefore, different jurisdictions interpret it differently and it has, as Overs and Loff argue, justified the punishment of sex workers.\(^\text{107}\) Some

sex workers in Kenya have vowed never to report violence incidents against them to the police because, even if they do, they hardly ever get help from them. Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, sought to clarify that Article 6 of CEDAW does not require states to suppress consensual adult sex work. Rather, Grover notes that the Convention calls for the suppression of all forms of traffic in women and exploitation of prostitution of women.

In similar fashion, other scholars claim that CEDAW rejects racism in its Preamble and that the Convention is generally silent on race, suggesting that it contemplates ‘a monolithic (white/Western/Northern) woman when the reality is quite different. Women around the world are richly diverse in terms of (among other things) race, sexuality, class, ethnicity, religion, culture, and gender.’ Yet, these flaws, according to Berta Hernández-Truyol, are not specific to CEDAW. Other treaties such as the Convention on the Elimination of All Forms of Racial Discrimination (CERD) have similar limitations.

Even so, both history and learning are not static, argues Hernández-Truyol. She posits that in earlier times, equality for women and racial minorities was inconceivable, let alone speaking their names. Rather than dismiss the current protections e.g. CEDAW, Hernández-Truyol encourages crafting new names and utilising interpretive tools to develop, expand and transform their meaning and content. In this way, Hernández-Truyol contends, CEDAW can be a living document that may be of use in modern times.

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110 Ibid.
111 CEDAW, The Preamble states that the ‘eradication of apartheid, all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women’.
113 Ibid 215.
114 Ibid.
115 Ibid.
116 Ibid.
117 Ibid.
Sex workers are guaranteed a right to equality before the law and a legal capacity under Article 15 of CEDAW.\textsuperscript{118} In its concluding observations on Kenya’s 7th State report, the CEDAW committee was concerned about poverty driving women and girls into prostitution to support themselves and their families,\textsuperscript{119} and it highlighted its concern with the way the law in Kenya only criminalised the supply and not the demand.\textsuperscript{120} Lack of data on trafficking and prostitution was equally a concern of the CEDAW Committee.\textsuperscript{121} The CEDAW Committee was concerned that sex workers in Kenya were at high risk of gender-based violence, including abuse by the police, murder, gang rape, extortion, robbery, forced sex practices and forced non-usage of condoms.\textsuperscript{122} The Committee further raised its concern about prejudice against sex workers, especially sex workers being fined or arrested when they pursued access to justice, social services and healthcare in Kenya.\textsuperscript{123} Thus, the Kenyan government was urged to:

(a) Take measures to eliminate violence against sex workers, including by the police, and that they should be able to report gender-based violence, including police violence, without fear of retribution or stigma;

(b) Decriminalise sex workers, remove all types of liability, including fines for sex workers;

(c) Ensure the prosecution and adequate punishment of perpetrators of violence against women in prostitution, including murders;

(d) Prohibit mandatory HIV and STI testing of sex workers following arrest, while encouraging women in prostitution to undergo voluntary HIV and STI testing;

(e) Adopt and implement adequate resources programmes and other appropriate measures to create educational and employment opportunities for women at risk of entering into sex work, as well as an exit programme for women wishing to leave prostitution;

(f) Implement educational and awareness-raising measures targeting the general public, in particular men and boys, to reduce the demand for sex workers. Such measures should put a particular focus on combating all notions of subordination of women and all forms of objectification of women.\textsuperscript{124}

\textsuperscript{118}CEDAW, Article 15.

\textsuperscript{119}CEDAW Committee, Concluding Observations: Kenya UN Doc CEDAW/C/KEN/CO/7, para 27; See para 28 where CEDAW Committee recommended to the Kenyan government to: ‘Conduct comparative studies on trafficking and prostitution to identify and address their root causes in order to eliminate the vulnerability of girls and women to sexual exploitation and traffickers and facilitate recovery and social integration of victims’ and ‘pursue a comprehensive approach in addressing the question of prostitution, including exit programmes for women who wish to leave prostitution and legislation to sanction the demand side.’

\textsuperscript{120}CEDAW Committee, Concluding Observations: Kenya UN Doc CEDAW/C/KEN/CO/7, para 27.

\textsuperscript{121}Ibid.

\textsuperscript{122}CEDAW Committee, Concluding Observations: Kenya CEDAW/C/KEN/CO/8 (n 81), para 28.

\textsuperscript{123}Ibid.

\textsuperscript{124}CEDAW Committee, Concluding Observations: Kenya CEDAW/C/KEN/CO/8 (n 81), para 29(a)-(f).
3.2.1.4 The Right to Health, including Sexual and Reproductive Health

The right to health is explicitly provided under international human rights law. At the international level, Article 12 of CEDAW obliges the Kenyan government to ‘take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure … access to health care services, including those related to family planning.’\textsuperscript{125} It further requires the Kenyan government to ‘ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.’\textsuperscript{126} On the other hand, Article 12 of the International Covenant on Economic, Social and Cultural Rights stipulates that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.\textsuperscript{127}

The General Recommendations No. 24 on Women and Health elaborate CEDAW Committee’s interpretation of Article 12 of the CEDAW Convention with a central aim of State parties to eliminate discrimination against all women in relation to their health especially sexual and reproductive health. In its General Recommendation No. 24 CEDAW Committee affirms women’s access to health care, including sexual and reproductive health as a basic right under the Convention,\textsuperscript{128} and that a woman’s health has to be addressed all through her life.\textsuperscript{129} The Committee recognises the effects unequal gender power relations have on women, making them more vulnerable to HIV/AIDS and sexually transmitted infections, and further identifies trafficked women and adolescents, including sex workers, as more vulnerable to HIV/AIDS.\textsuperscript{130} The Committee recommends that state parties ensure women and girls’ right to sexual and reproductive health information, including those who have been trafficked, whether

\textsuperscript{125} CEDAW, Article 12(1).
\textsuperscript{126} Ibid Article 12(2).
\textsuperscript{127} ICESCR, Article 12.
\textsuperscript{128} CEDAW Committee, General Recommendation No 24 on Women and Health, para 1.
\textsuperscript{129} Ibid para 8.
\textsuperscript{130} Ibid para 6 and 18.
they are legal residents of that state or not\textsuperscript{131} according to the international human rights law to protect them against human rights violations.

In its concluding observations, the CEDAW Committee expressed its concern over the inadequate recognition and protection of the reproductive health and rights of Kenyan women\textsuperscript{132} and the lack of access to quality healthcare for many women (including sex workers).\textsuperscript{133} The CEDAW Committee was concerned with the restrictive and unclear abortion law that results in unsafe and illegal abortions, including high rates of HIV/AIDS in Kenya.\textsuperscript{134} In its 2012 updated ‘Safe Abortion: Technical and Policy Guidance for Health Systems’, World Health Organisation defined unsafe abortion as ‘a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.’\textsuperscript{135}

The Committee urged the Kenyan government to strengthen its efforts to ensure access for all women, including women with disabilities and sex workers, to healthcare facilities and medical assistance by trained personnel, especially in rural areas.\textsuperscript{136} It further asked the government to amend the Kenyan Penal Code Chapter 63 Laws of Kenya to allow abortion in cases of rape, incest and severe foetal impairment, as well as in cases of risk to the health and life of the mother and also ensure access to quality post-abortion care.\textsuperscript{137} The CEDAW Committee urged Kenya to adopt the Reproductive Health Rights Bill and increase the national health budget allocation in accordance with the Abuja Declaration.\textsuperscript{138} Scholars have cautioned that unless women can access safe termination of pregnancy, addressing the complications of unsafe abortion, will

\textsuperscript{131} Ibid para 18.
\textsuperscript{132} CEDAW Committee, Concluding observations Kenya UN Doc. CEDAW/C/KEN/CO/7, para 37; See also para 38(a).
\textsuperscript{133} CEDAW Committee, Concluding Observations: Kenya CEDAW/C/KEN/CO/8 (n 81), para 38.
\textsuperscript{134} Ibid.
\textsuperscript{136} CEDAW Committee, Concluding Observations: Kenya CEDAW/C/KEN/CO/8 (n 81), para 38(a), (e) (h) and (i); See also CEDAW Committee, Concluding observations: Kenya UN Doc CEDAW/C/KEN/CO/7, para 37.
\textsuperscript{137} Ibid.
\textsuperscript{138} Ibid.
continue to impose a great financial burden on the constrained resources of health systems in countries like Kenya and others in the global south.\(^{139}\)

CESCR Committee elaborates on Article 12 of ICESCR through its General Comment No. 14 of 2000 which recognises that everyone has the right to enjoy the highest attainable standard of physical and mental health. Kenyan Courts have demonstrated that the right to health cannot effectively be protected without respect for other human rights, for example, prohibition of discrimination and the right of persons to participate in decisions that affect them.\(^{140}\) In the case of *Matthew Okwanda v Ministry of Health and Medical Services & 3 Others*,\(^{141}\) the High Court in Kenya invoked General Comment No. 14 with emphasis that health is a fundamental human right indispensable for the exercise of other human rights. General Comment No. 14 makes it clear that the right to health contains both freedoms and entitlements and it does not mean a right to be healthy.\(^{142}\) Under paragraph 12, the essential elements of availability, accessibility, acceptability and quality, important for the right to health are addressed.\(^{143}\) The General Comment further points out to the States to remove all barriers to the realisation of women’s right to health including domestic violence.

*To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women’s health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realisation of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.*\(^{144}\)

\(^{142}\) CESC\(\)R Committee, General Comment No 14 on the Right to the Highest Attainable Standard of Health, para 8.
\(^{143}\) Ibid para 12.
\(^{144}\) Ibid para 21.
Until 2016, General comment No. 14 of 2000, on the right to the highest attainable standard of health, included sexual and reproductive health.\(^{145}\) In May 2016, the CESCRL Committee for the first time adopted General Comment No. 22, on sexual and reproductive health rights consisting of 64 paragraphs and recognising SRHR as an integral part of the right to health enshrined in Article 12 of ICESCR.\(^{146}\) General Comment No. 22 aims to assist state parties in their implementation of ICESCR in their countries so as to fulfil their reporting obligations.\(^{147}\) State parties’ reports are required to be comprehensive and also to contain four interconnected and essential elements on availability,\(^{148}\) accessibility,\(^{149}\) acceptability,\(^{150}\) and quality\(^{151}\) of sexual and reproductive health. States parties have a core obligation under General Comment No. 22:

(a) To repeal or eliminate laws, policies and practices that criminalise, obstruct or undermine individual’s or particular group’s access to sexual and reproductive health facilities, services, goods and information;
(b) To adopt and implement a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health, which is devised, periodically reviewed and monitored through a participatory and transparent process, disaggregated by the prohibited grounds of discrimination;
(c) To guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalised groups;
(d) To enact and enforce the legal prohibition of harmful practices and gender-based violence, including female genital mutilation, child and forced marriages and domestic and sexual violence including marital rape, while ensuring privacy, confidentiality and free, informed and responsible decision-making, without coercion, discrimination or fear of violence, on individual’s sexual and reproductive needs and behaviours;
(e) To take measures to prevent unsafe abortions and to provide post-abortion care and counselling for those in need;
(f) To ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health, that is non-discriminatory, non-biased, evidence-based and taking into account evolving capacities of children and adolescents;
(g) To provide medicines, equipment and technologies essential to sexual and reproductive health including based on the WHO Essential Medicines List; and
(h) To ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health.\(^{152}\)

\(^{146}\) Ibid.
\(^{147}\) Ibid para 3.
\(^{148}\) Ibid paras 12-14.
\(^{149}\) Ibid paras 15-19.
\(^{150}\) Ibid para 20.
\(^{151}\) Ibid para 21.
\(^{152}\) Ibid para 49.
This new comment reinforces the challenges women and groups such as sex workers and lesbian, gay, bisexual, transgender and intersex persons, face in their realisation of the right to sexual and reproductive health. The General Comment acknowledges that there are legal, procedural, practical and social barriers which inhibit access to the full range of sexual and reproductive health facilities, services, goods and information. With General Comment No.22, the Kenyan government has to ensure that its next state report to the CESCR Committee address the situation of sexual and reproductive health rights of women throughout the country. A human rights-based approach to development supports the monitoring of State commitments with the help of recommendations of human rights treaty bodies. Therefore, it is important that sex workers and other marginalised groups in Africa make use of the opportunity to expose their experiences in their different countries through Shadow reports to CESCR Committee and other human rights treaty bodies.

In its concluding observations on the combined second to fifth periodic reports to Kenya adopted on 4 March 2016, the Committee on Economic, Social and Cultural Rights (CESCR Committee) was concerned with the long delays in adopting laws and policies that are crucial to the realisation of economic, social and cultural rights enshrined in the Constitution. The committee regretted the regional disparities in access to healthcare services and the delay in enacting the Health Bill, as well as the inadequate budget allocation to the health sector in compliance with Article 12 of ICESCR. On sexual and reproductive health, the CESCR was particularly concerned at the ‘criminalisation of abortion under any circumstance provided in the Penal Code, the large number of unsafe abortions and the consistent high rate of maternal mortality’ and further at ‘cases of post-delivery detention of women unable to pay their medical bills in health-care facilities,’ including the ‘limited access to sexual and reproductive health information and services as well as contraceptives, especially for women living in the rural areas.’ Notably, the CESCR committee expressed its concern over pervasive corruption in the public sector.

153 Ibid para 2.
154 Ibid.
156 Ibid para 51.
157 Ibid para 53.
158 Ibid para 53.
159 Ibid para 53.
160 Ibid para 17.
3.2.1.5 The Right to Information

International human rights law guarantees the right to information. It acknowledges the significant role the right has to play for women including sex workers and women with disability to make informed sexual and reproductive health decisions. Specifically, the right to ‘access to specific educational information … including information and advice on family planning, is articulated in Article 10(h) of CEDAW.’\(^{161}\) Approximately 70 per cent of Kenya’s population live in the rural areas.\(^{162}\) Given the historical context as critically examined in chapter one, women in Africa, still make a big population in the villages and men in the cities. However, CEDAW require State parties to ensure that the rights of women in urban and rural areas in their respective countries are respected, protected and fulfilled.

As clearly stated in Article 14(2)(b) of CEDAW Convention, the women in the rural areas have the right ‘to have access to adequate health care facilities, including information, counselling and services in family planning.’\(^{163}\) Further, Article 16(1)(e) of CEDAW requires State parties to take all appropriate measures to ensure women’s right ‘to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.’\(^{164}\) Sex work does not take away a sex worker’s right to information. My empirical research findings in chapters five and six reveal that, in practice, sex workers have been excluded from access to information as the policy maker and BHESP representative expressed at sections 5.1.5 and 6.2.1.3.

3.2.2 The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa

In this section, I explore Maputo Protocol for the protection it offers to women and their rights in Africa. It recognises that African women and men are equal before the law and shall have the right to equal protection and benefit of the law.\(^{165}\) At the regional level,

\(^{161}\) CEDAW, Article 10(h).
\(^{163}\) CEDAW, Article 14(2)(b).
\(^{164}\) Ibid Article 16(1)(e).
the Maputo Protocol reflects both the universal and the regional. In Frans Viljoen’s work on *International Human Rights Law in Africa*, he argues that ‘Africanness’ of African regional treaties can be measured according to the degree to which they address ‘the most pressing and specific human rights violations in Africa’ as well as the degree to which they reflect African tradition. Although Maputo Protocol does not mention sex workers, it provides a progressive and bold path in the articulation of women’s sexual and reproductive health rights including abortion. Abortion is a contentious issue in Kenya and much of Africa and to have an African regional treaty explicitly address the issue brings reality home. Maputo Protocol is the first treaty that explicitly recognise abortion as a woman’s right, to guarantee women’s protection in terms of HIV and AIDS and to affirm that sexual and reproductive health rights are human rights.

Despite criticism particularly on its drafting, Ngwena et al., have described the African Women’s Protocol as ‘the fruit of advocacy by women’s organisations in the African region’, Gertholtz et al., ‘a tool for ensuring universal access to reproductive health and the creation of an enabling environment’ and Viljoen ‘a shield for women in Africa’. Following the 1993 Vienna Human Rights Conference, the Organisation of African Unity (now African Union) passes a resolution requiring the African Commission on Human and Peoples’ Rights to draft an additional Protocol to the African Charter on Human and Peoples’ Rights to elaborate on the rights of women in

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167 Ibid.
171 Ngwena et al., ‘Human Rights Advances in Women’s Reproductive Health in Africa’ (n 39).
Africa.\textsuperscript{174} The Maputo Protocol was later to enter into force in the shortest time in OAU/AU history, following lobbying by the African women’s movement.\textsuperscript{175} Special Rapporteurs have amplified the voices of women on sexual and reproductive health rights both in internationally and in the region, e.g. the Special Rapporteur on the right to the highest attainable standard of physical and mental health\textsuperscript{176} and the Special Rapporteur on the Rights of Women in Africa whose mandate includes to:

\textit{Follow up on the implementation of the African Charter on Human and Peoples' Rights and its Protocol relative to the Rights of Women in Africa by State Parties, notably by preparing reports on the situation of women rights in Africa and propose recommendations to be adopted by the Commission.}\textsuperscript{177}

Maputo Protocol defines violence against women in Africa as:

\textit{All acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life ...}\textsuperscript{178}

The Protocol guarantees women and men in Africa equality before the law and equal protection and benefit of the law and requires State parties to ‘take all appropriate measures to ensure reform of the existing discriminatory laws and practices in order to promote and protect the rights of women.’\textsuperscript{179} Arguably, lack of transparency and accountability in sexual and reproductive health-related laws and policies generally deny women including sex workers substantive equality and equal protection under the law.\textsuperscript{180}

\textsuperscript{174} The Organization of African Unity (OAU) was established on 25 May 1963. It was disbanded on 9 July 2002 by its last chairperson, South African President Thabo Mbeki, and was replaced by the African Union (AU) in P Gosh, \textit{International Relations} (PHI Learning Pvt Ltd 2016) 224.


\textsuperscript{179} Ibid Article 8(f).

\textsuperscript{180} S Mavundla and CG Ngwena, ‘Access to Legal Abortion for Rape as a Reproductive Health Right: A Commentary on the Abortion Regimes of Swaziland and Ethiopia’ in C Ngwena and E Durojaye (eds),
Article 14(1) of Maputo Protocol guarantees women in Africa the rights to control their fertility, access contraception, family planning, education and abortion, without any discrimination. It states that:

1. State Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.
   (a) the right to control their fertility;
   (b) the right to decide whether to have children, the number of children and the spacing of children;
   (c) the right to choose any method of contraception;
   (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;
   (e) the right to be informed on one’s health status and on the health status of one’s partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
   (f) the right to have family planning education.

2. State Parties shall take all appropriate measures to:
   (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
   (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding;
   (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.\textsuperscript{181}

\textsuperscript{181} Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (2003), Article 14 on ‘health and reproductive rights’; Article 2 on the Elimination of Discrimination against Women states that:

1. State parties shall combat all forms of discrimination against Women through Appropriate legislative, institutional and other measures. In this regard they shall:
   (a) include in their national constitutions and other legislative instruments, if not already done, the principle of equality between women and men and ensure its effective application;
   (b) enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women;
   (c) integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life;
   (d) take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist;
   (e) support the local, national, regional and continental initiatives directed at eradicating all forms of discrimination against women.

2. State Parities shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either the sexes, or on stereotyped roles for women and men.
Human rights are indivisible, interdependent and interrelated and discrimination and equality are vital principles for the realisation of rights as stated in chapter two. The African Commission held in *Purohit and Moore v The Gambia*,\(^{182}\) that the enjoyment of the right to health is crucial to the realisation of other fundamental human rights and freedoms.\(^{183}\) That it includes the right to non-discriminatory health facilities, access to goods and services to all.\(^{184}\) Significantly, the African Commission has in *Egyptian Initiative for Personal Rights and Interights v Egypt*,\(^{185}\) recognised gender-based violence as both discrimination and a human rights violation. In pronouncing this decision, the Commission calls upon African states to take steps to prevent acts of gender-based violence against all women and girls in Africa.

The African Commission has adopted General Comments to assist in interpretation of the sexual and reproductive health rights provisions in the Maputo Protocol. State parties to Maputo Protocol are required to use them in the preparing and submitting their State reports to the African Commission.\(^{186}\) Article 45(1)(b) of the African Charter on Human and Peoples’ Rights mandates the African Commission to ‘formulate and lay down, principles and rules aimed at solving legal problems relating to human and peoples’ rights and fundamental freedoms upon which African Governments may base their legislation’.\(^{187}\) In 2012, and for the first time in the history of the African Commission, it adopted General Comment No.1 on Articles 14(1)(d) and (e) of the Maputo Protocol at its 52nd Ordinary Session held in Yamoussoukro, Cote d’Ivoire with the support of the Centre for Human Rights, University of Pretoria.\(^{188}\) The general comments recognise that the high risk of HIV is an obstacle to women in Africa, and sex workers in particular, for their enjoyment of sexual and reproductive health rights in Africa.\(^{189}\) In 2014, the Commission adopted the next General Comment No. 2 on

\(^{182}\) (2009) AHRLR 75 (ACHPR 2009).
\(^{183}\) Ibid [81].
\(^{184}\) Ibid.
\(^{188}\) Asuagbor, (n 186).
\(^{189}\) Ngwena and Durojaye, “Strengthening the Protection of Sexual and Reproductive Health through Human Rights in the African Region: An introduction” (n 165) 2-4; See also L Forman, “The Right to
Articles 14(1)(a), (b), (c) and (f) and Articles 14(2)(a) and (c) as its second general comment at its 55th Ordinary Session in Luanda, Angola.\textsuperscript{190}

The African Commission on Human and Peoples’ Rights monitors the compliance and implementation of State parties’ obligations under the Maputo Protocol.\textsuperscript{191} The African Commission can hear individual complaints (communications), although their decisions have no binding effect on State parties.\textsuperscript{192} However, the African Commission is not without its shortcomings as Frans Viljoen comments:

\textit{In almost a quarter of a decade, the Commission has only “handled” a total of 442 communications, of which 361 had been “finalised”. This number is not only strikingly lower than the number of cases in the other regional systems, but also a drop in the ocean considering the pool of potential cases. It must be abundantly clear that 17 cases per year, in a vast continent comprising 53 AU member states, is unacceptably low.}\textsuperscript{193}

While this is a sign that human rights violation cases in Africa are getting audience at the regional level, the numbers are surprisingly low particularly in a continent where millions of people are deprived of even the most basic necessities of life as Viljoen has further pointed out.\textsuperscript{194} It is argued that delays in dealing with cases brought before the African Commission on one hand, and the African Children’s Rights Committee on the other have ‘eroded public confidence and trust’ in them.\textsuperscript{195} In my view when such standards are set at the African Commission, women in the region face more challenges in the enforcement of their sexual and reproductive health rights protected under the Maputo Protocol not to mention when State parties e.g. Kenya do not comply with the

\textsuperscript{190} Ngwena et al., ‘Human Rights Advances in Women’s Reproductive Health in Africa’ (n 39) 184.
\textsuperscript{191} Brookman-Amissah and Kachika, ‘Reducing Abortion-Related Maternal Mortality in Africa: Progress in Implementing Objective 5 of the Maputo Plan of Action on Sexual and Reproductive Health Rights’ (n 50) 46.
\textsuperscript{192} Ibid.
\textsuperscript{195} Viljoen, ‘From a Cat into a Lion? An Overview of the Progress and Challenges of the African Human Right System at the African Commission’s 25 Year Mark’ (n 193) 308.
Commission’s State Reporting Guidelines on Maputo Protocol\textsuperscript{196} and in the end fail to expose human rights including sexual and reproductive health-related violations of women in Kenya. State reports are key for a meaningful engagement. In ‘African Human Rights Law in Theory and Practice’ Killander offers critique of the African human rights system for lack of availability of the State reports which often impedes meaningful input from the civil society to the whole reporting system.\textsuperscript{197}

Nonetheless, Kenya’s effort in relation to state-reporting process on the African Charter has been acknowledged for ‘participatory and transparency’.\textsuperscript{198} But this is not to say that lack of consultation in preparation for its State reports has gone unnoticed. As Killander pointed out above, earlier, in 2007 the Commission raised its concern in its concluding observations and recommendations to Kenya, the government’s failure to consult with civil society in the preparation of its reports,\textsuperscript{199} and inadequate budget allocation to its health sector.\textsuperscript{200}

The African Commissions raised concerns that restricted the enjoyment the enjoyment of rights embodied in the African Charter and include poverty among women and gender-based violence which remain widespread in Kenya;\textsuperscript{201} the HIV pandemic ravaging the Kenyan population due to the fact that many people infected have limited resources to get appropriate drugs;\textsuperscript{202} and the low level of women’s representation in decision-making institutions in the government, including in appointed positions.\textsuperscript{203} The Kenyan government was tasked through the Commission’s concluding observations and recommendations, to take steps to ensure that women participate in decision-making in

\textsuperscript{197} M Killander, ‘African Human Rights Law in Theory and Practice’ in S Joseph and A McBeth (eds), 
\textsuperscript{200} Ibid para 44(i).
\textsuperscript{202} Ibid para 35.
\textsuperscript{203} Ibid para 40.
the country\textsuperscript{204} and ensure consultation with NGOs and academic institutions, in the preparation of State reports to the Commission at the regional level and other treaty-monitoring bodies at the international level.\textsuperscript{205} The Commission equally urged Kenya to enact a comprehensive equality and non-discrimination law and to comply with the Commission’s State Reporting Guidelines under the Maputo Protocol.\textsuperscript{206} Article 62 of the African Charter requires each State party to the Charter to submit State reports every two years.\textsuperscript{207} State parties are required under Article 26 on implementation and monitoring of the Protocol to ‘ensure the implementation of this Protocol at the national level, and in their periodic reports submitted in accordance with Article 62 of the African Charter, indicate the legislative and other measures undertaken for the full realisation of the rights herein recognised’ and ‘adopt all necessary measures and in particular shall provide budgetary and other resources for the full and effective implementation of the rights herein recognised.’\textsuperscript{208} 

In \textit{Dorothy Chioma Njemanze \& 3 Others v Federal Republic of Nigeria},\textsuperscript{209} the Economic Community of West African States (ECOWAS) Court of Justice found Nigeria to be in contravention of Articles 2, 3, 4(1) and (2), 5, 8 and 25 of Maputo Protocol and Articles 2, 3, 5 (a), and 15 (1) of CEDAW.\textsuperscript{210} It is a notable first for a regional-level court to pronounce violations of the Maputo Protocol.\textsuperscript{211} Secondly, this case addresses the issue of sex workers where women were harassed by law enforcers, arrested on the streets and accused of prostitution at the same time invoking protections under CEDAW.

\textsuperscript{204} Ibid para 51.
\textsuperscript{205} Ibid para 55.
\textsuperscript{209} Suit No. ECW/CCJ/APP/17/14; ECW/CCJ/JUD/08/17 (ECOWAS Court, Abuja, Nigeria)
\textsuperscript{210} Ibid.
As of December 2017, Kenya had submitted eighth periodic reports to the CEDAW Committee.\textsuperscript{212} A combined first and second report was submitted in 1993, a third and fourth report in 2004, a fifth and sixth report in 2007, a seventh report in 2011 and, in 2017, an eight state report.\textsuperscript{213} At the regional level, more than a decade after ratification of the African Charter in 1992, Kenya submitted its 1st to 7th state reports as its initial report to the African Commission on Human and Peoples’ Rights at its 41st Ordinary Session held in Accra, Ghana, from 16 to 30 May 2007\textsuperscript{214} and its 8th to 11th state reports for the period 2008 to September 2014 (submitted in December 2014) at its 19th Extra-Ordinary Session held from 16 to 25 February 2016 in Banjul, The Gambia.\textsuperscript{215}

\subsection*{3.2.3 Kenya and its Reservations}

The Vienna Convention on the Law of Treaties (1969) defines a reservation as ‘a unilateral statement, however phrased or named made by a state, when signing, ratifying, accepting, approving or acceding to a treaty, whereby it purports to exclude or to modify the legal effect of certain provisions of the treaty in their application to that state.’\textsuperscript{216} With its ratification of CEDAW, ICESCR and the Maputo Protocol, the government of Kenya commits to refrain from any omission or commission that may defeat the purpose of those treaties.\textsuperscript{217} While at the international level Kenya has ratified CEDAW without any reservations, it has nonetheless made reservations under ICESCR. Together with several State parties have entered declarations and reservations of varying significance to their acceptance of the obligations under the Covenant.\textsuperscript{218}

\begin{itemize}
\item \textsuperscript{213} Ibid.
\item \textsuperscript{216} Vienna Convention on the Law of Treaties 1969, Article 2(1)(d).
\item \textsuperscript{218} M Ssenyonjo, ‘State Reservations to the ICESCR: A Critique of Selected Reservations’ (2008) 26:3 Netherlands Quarterly of Human Rights 315, 318 (Afghanistan; Algeria; Bangladesh; Barbados; Belgium; Bulgaria; China; Denmark; Egypt; France; Guinea; Hungary; India; Indonesia; Iraq; Ireland; Japan; Kuwait; Libyan Arab Jamahiriya; Madagascar; Malta; Mexico; Monaco; Mongolia; the Netherlands; New Zealand; Norway; Pakistan; Romania; Russian Federation; Rwanda; Sweden; Syrian Arab Republic; Thailand; Trinidad and Tobago; Turkey; Ukraine; the United Kingdom of Great Britain and Northern Ireland; Vietnam; Yemen; and Zambia).
\end{itemize}
Kenya’s reservation is placed to limit the application of Article 10(2) of ICESCR which specifically focuses on women, in particular, the working mothers. The article states that ‘special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.’

The reservation to the ICESCR provision reads, ‘while the Kenya government recognises and endorses the principles laid down in paragraph 2 of Article 10 of the Covenant, the present circumstances obtaining in Kenya do not render necessary or expedient the imposition of those principles by legislation.’ As Manisuli Ssenyonjo articulates it, to encourage withdrawal, State parties have to review regularly the reservations. The CESCR Committee has urged the Kenyan government to withdraw its reservation. Unlike the Optional Protocol to CESCR which is silent, Article 17 of the Optional Protocol to CEDAW does not allow any reservations to be made to the Convention. The Kenyan government needs to ratify these Protocols so as to pave the way for Kenyan women to take complaints before CEDAW and CESCR Committees.

The Kenyan government and other African countries e.g. Cameroon have entered reservations on Maputo Protocol restricting implementation of for example in the case of Kenya, Articles 10(3) and 14(2)(c). The reservations placed on two provisions of the Protocol by the Kenyan government state that: ‘The Government of the Republic of Kenya does not consider as binding upon itself the provisions of Article 10(3) and Article 14(2)(c) which is inconsistent with the provisions of the Laws of Kenya on health and reproductive rights.’ While Article 14(2)(c) as seen above address

219 ICESCR, Article 10(2).
221 Ssenyonjo (n 222).
223 Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women 1999 A/RES/54/4, Article 17; CEDAW Committee, Eighth Periodic Report Kenya UN Doc. CEDAW/C/KEN/8 (2016), para 15 where Kenya stated in its Periodic report that: ‘The government of Kenya has committed to acceding to the optional protocol to CEDAW to allow individuals violated to access the CEDAW committee after exhausting domestic remedy. This process is being spearheaded by the Department of Justice under the Attorney General.’
African woman’s right to abortion, Article 10(3) specifically requires African governments to ‘take the necessary measures to reduce military expenditure significantly in favour of spending on social development in general, and the promotion of women in particular.’ On the other hand, and as already discussed above, Maputo Protocol does not mention sex workers in any way but the government of Cameroon is one of the African countries that explicitly mentions ‘prostitution’ and ‘homosexuality’ in its reservation which ordinarily excludes these vulnerable groups in that country from the human rights protection that they so need. It states that:

*The acceptance of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa should in no way be construed as endorsement, encouragement or promotion of homosexuality, abortion (except therapeutic abortion), genital mutilation, prostitution or any other practice which is not consistent with universal or African ethical and moral values, and which could be wrongly understood as arising from the rights of women to respect as a person or to free development of her personality. Any interpretation of the present Protocol justifying such practices cannot be applied against the Government of Cameroon.*

Reflecting on the Kenya’s old constitutional order under which Article 10(2) of ICESCR reservation was made and the new constitutional dispensation, I argue that, it is time for the Kenyan government to remove the reservations on both ICESCR and Maputo Protocol to ensure that constitutionalised rights of women including the right to the highest attainable standard of physical and mental health are fully respected, protected and fulfilled. In a country with a Constitution and laws and policies that claim to be rights-based, and which for the first time since independence embodies several specific gains the Kenyan women struggled for, e.g. elimination of gender discrimination in relation to land matters, marriage and citizenship, the government has to show its commitment to implement women’s rights.

### 3.3 The Constitutional Legal Framework in Kenya

At the national level, the Constitution of Kenya 2010, the supreme law of the land, entrenches the provisions recognised under CEDAW, ICESCR and the Maputo Protocol

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226 Asuagbor, (n 186).
outlined above, which are necessary for the enforcement of sexual and reproductive health rights of sex workers in the country. The 2010 Constitution specifically provides in Article 2(4) that: ‘Any law, including customary law, that is inconsistent with this Constitution is void to the extent of the inconsistency, and any act or omission in contravention of this Constitution is invalid.’ The 2010 Constitution entrenches economic, social and cultural rights, a gesture which Fareda Banda particularly equates to recognition of the problems that affect the Kenyan population, the majority of whom are women. According to Banda, such a constitutional change in Kenya may seem to be easy, but remains sceptical about its implementation, particularly the long-term commitment it demands to ensure human rights, especially for women, are respected and protected. Similar to the Constitution of South Africa 1996, scholars have described the Kenyan Constitution as a ‘human rights-based Constitution’. It contains what Andrews and Hines identify as ‘an impressive series of human rights provisions.’ The Preamble recognises the ‘aspirations of all Kenyans for a government based on the essential values of human rights, equality, freedom, democracy, social justice and the rule of law,’ and reaffirms unlike the post-independence Constitution, the acceptance by all Kenyans to adopt the Constitution for themselves and for all future generations.

It is important to point out further to Article 2(4) that no treaty in Kenya can be ratified without prior consideration and approval by the cabinet and parliament. The Constitution in Article 21(4) states that ‘the State shall enact and implement legislation to fulfil its international obligations in respect of human rights and fundamental

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freedoms. The Kenyan parliament therefore has a significant role to play in ensuring compliance with internationally recognised obligations. The law on ratification of treaties, The Treaty Making and Ratification Act Cap No. 45 of the Laws of Kenya was passed in 2012. It gives ‘effect to the provisions of Article 2(6) of the Constitution and to provide the procedure for the making and ratification of treaties and connected purposes.’ Anyone who contravenes this law is liable to imprisonment for a term not exceeding fifteen years or to a fine not exceeding twenty million Kenya shillings or both.

Thus, Article 94(5) stipulates that ‘no person or body, other than Parliament, has the power to make provision having the force of law in Kenya except under authority conferred by this Constitution or by legislation.’ The government of Kenya sees this as an assurance to Kenyans that all laws coming from outside the country shall be vetted before they are adopted in order to ‘offer Kenyans the comfort that international norms and practices that are contrary to the people’s beliefs and customs can be avoided through parliament.’ While the reassurance could be comforting, women in Kenya and other marginalised groups I argue, have to remain vigilant and demand participation and legislative transparency and accountability to ensure that their sexual and reproductive health rights protected in the Bill of Rights are not compromised.

The Bill of Rights in the 2010 Constitution provides the framework for social, economic and cultural policies in Kenya and it is recognised as an integral part of Kenya’s democratic State. The Bill aims to ‘preserve the dignity of individuals and communities’ as well as ‘to promote social justice and the realisation of the potential of all human beings.’ The Kenyan Constitution affirms that the rights and fundamental freedoms contained in its Bill of Rights, are not granted by the State and that they belong to each individual including women in Kenya. It further affirms that the said

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239 Ibid Section 12.
240 Constitution of Kenya, Article 95(5).
243 Ibid Article 19(2).
244 Ibid Article 19(3)(a).
rights and fundamental freedoms ‘do not exclude other rights and fundamental freedoms not in the Bill of Rights but recognised or conferred by law’ for as long as they are consistent with the Constitution. In enforcing the Bill of Rights which contains Article 43 on the right to the highest attainable standard of health including reproductive health care, the Kenya’s Constitution stipulates that ‘every person [including vulnerable and marginalised groups] has the right to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed or is threatened.’ Empowerment of sex workers to understand the rights contained in the Bill of Rights and to be able to claim in relation to violations directed unto them is the focus of the thesis.

For the first time, the Kenyan Constitution 2010 places a strong emphasis on vulnerable and marginalised groups, and these include women, sex workers and other key populations. Article 21(3) of the Constitution requires the needs of these vulnerable groups to be addressed and puts responsibility on the state organs and public officers as it provides that:

All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities.

Godfrey Odongo and Godfrey Musila argue that:

... the implementation of the various economic, social and cultural rights under Kenya’s Constitution will depend on the development, enactment, review and implementation of the relevant and appropriate laws and policies. The existence of deep-seated structural obstacles to the realisation of these rights in Kenya demands, on the one hand, the deployment of general and specific policies that address systemic inequalities in society and open up spaces for all people to have equal access to opportunities and, on the other hand, the availability of opportunities for aggrieved persons to seek remedies through the courts for any alleged violations of these rights.

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245 Ibid Article 19(3)(b).
246 Constitution of Kenya 2010, Article 22(1).
248 Constitution of Kenya 2010, Article 21(3).
According to Odongo and Musila, the Constitution has provided Kenyans (including sex workers), with ‘new tools’ to hold the government accountable, particularly in terms of its social policy including sexual and reproductive health.\textsuperscript{250} Importantly, it has empowered Kenyans (including women and especially sex workers), to be able to bring claims before the courts on the government’s failures, and further created an opportunity for courts to make decisions on the impact of the provisions of the Constitution on both women and men.\textsuperscript{251} This, Odongo and Musila contend, was not possible under Kenya’s old Constitution, which did not protect these rights directly.\textsuperscript{252}

### 3.3.1 The Right to Non-Discrimination and Equality in Kenya

Equality and freedom from discrimination are guarantees provided under the Constitution of Kenya 2010. As findings in chapter six show, discrimination and violence against sex workers are obstacles that make access to sexual and reproductive health goods, services and facilities difficult. They violate several rights including the right to privacy protected under Article 28 which articulates that ‘every person has inherent dignity and the right to have that dignity respected and protected.’\textsuperscript{253} The Kenyan Constitution makes it unlawful to discriminate anyone whether directly or indirectly in the country. Nonetheless, the reality on the ground in relation to sex workers and other vulnerable groups is different.\textsuperscript{254} Article 27 on equality and freedom from discrimination states that:

1. Every person is equal before the law and has the right to equal protection and equal benefit of the law.
2. Equality includes the full and equal enjoyment of all rights and fundamental freedoms.
3. Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres.
4. The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.
5. A person shall not discriminate directly or indirectly against another person on any of the grounds specified or contemplated in clause (4).
6. To give full effect to the realisation of the rights guaranteed under this Article, the State shall take legislative and other measures, including affirmative action programmes and policies designed to redress any disadvantage suffered by individuals or groups because of past discrimination.

\begin{itemize}
\item \textsuperscript{250} Ibid 370. \\
\item \textsuperscript{251} Ibid. \\
\item \textsuperscript{252} Ibid. \\
\item \textsuperscript{253} Constitution of Kenya 2010, Article 28. \\
\item \textsuperscript{254} Ibid Article 27.
\end{itemize}
(7) Any measure taken under clause (6) shall adequately provide for any benefits to be on the basis of genuine need.

(8) In addition to the measures contemplate in clause (6), the State shall take legislative and other measures to implement the principle that not more than two thirds of the members of elective of appointive bodies shall be of the same gender.\(^\text{255}\)

The 2010 Constitution prohibits discrimination on several grounds. Having these constitutional rights clearly stated in the Constitution is a good thing for the women of Kenya. However, the challenge remains to ensure this protection becomes a daily reality in the lives of the Kenyan women. The Kenyan sex workers’ Shadow report to CEDAW indicate that the women who do sex work are ‘unable to access comprehensive health care services, particularly sexual and reproductive health services for fear of discrimination against us from health care providers.’\(^\text{256}\) The report also indicates that the police and the judiciary discriminate against sex workers hence reduce their ability to report perpetrators and to have their cases investigated and successfully prosecuted in court.\(^\text{257}\) I argue that when the police who have a duty to protect sex workers against violence and other violations, and the judiciary whose role is to enforce sex workers constitutional rights, discriminate sex against workers, it exacerbate difficulties in realising sexual and reproductive health rights.

3.3.2 The Right to Health including Sexual and Reproductive Health in Kenya

Other constitutions in the global south recognise explicitly the right to health,\(^\text{258}\) e.g. the Constitutions of the Federal Republic of Nigeria of 1999\(^\text{259}\) and South Africa.\(^\text{260}\) In the

\(^{255}\) Ibid Article 27(4).
\(^{256}\) Kenya Sex Worker Alliance (KESWA) and Bar Hostess Empowerment and Support Program (BHESP), Kenya Sex Workers’ Shadow Report Submission to the United Nations Committee on the Elimination of Discrimination against Women 68th Session (KESWA and BHESP 2017) 6.
\(^{257}\) Kenya Sex Worker Alliance (KESWA) and Bar Hostess Empowerment and Support Program (BHESP), Kenya Sex Workers’ Shadow Report Submission to the United Nations Committee on the Elimination of Discrimination against Women 68th Session (KESWA and BHESP 2017).
\(^{258}\) Office of the United Nations High Commissioner for Human Rights (OHCHR) and World Health Organisation (WHO), ‘The Right to Health’ (Fact Sheet No 31, OHCHR 2008) 10
\(^{259}\) Constitution of the Federal Republic of Nigeria 1999, Section 17(3) provides that: The State shall direct its policy towards ensuring that:

\[\ldots\]

- (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;
- (d) there are adequate medical and health facilities for all persons.

See Ahamefule v Imperial Medical Centre & Dr. Alex K Molokwu Suit No ID/1627/2000.

\(^{260}\) Constitution of South Africa 1996, Article 27 (1) guarantees that:

- (1) Everyone has the right to have access to—
  - (a) health care services, including reproductive health care;
Indian Constitution the right to health is not explicitly included. Article 47 of the Constitution of India (1950) makes it a primary responsibility of the State to improve public health and provides that: ‘The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties …’ In this situation, where the right to health has not explicitly been provided in the domestic law, the Supreme Court of India for example has interpreted Article 21 of the Indian Constitution on the protection of life and personal liberty to include the right to health. In a 1989 landmark ruling, the Indian Supreme Court held in *Paramanand Katara v Union of India* that the right to life includes the protection of health.

In Kenya, the Constitution guarantees women including those in sex work the right to life and to privacy. Article 43 of the 2010 Constitution on ‘economic and social rights’ explicitly provides the right to health and to emergency medical treatment and states that:

1. Every person has the right –
   (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;
   (b) to accessible and adequate housing, and to reasonable standards of sanitation;
   (c) to be free from hunger, and to have adequate food of acceptable quality;
   (d) to clean and safe water in adequate quantities;
   (e) to social security; and
   (f) to education.


(b) sufficient food and water;

... 

(2) The State must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of these rights.

(3) No one may be refused emergency medical treatment.

See *The Government of RSA and Others v Grootboom and Others* 2000 11 BCLR 1169 (CC) and *Minister of Health v Treatment Action Campaign (TAC)* 2002 5 SA 721 (CC).

Constitution of India 1950, Article 47.

Ibid Article 21 states that: ‘No person shall be deprived of his life or personal liberty except according to procedure established by law.’

Constitution of Kenya 2010, Article 26 (1).

Ibid Article 31 states: Every person has the right to privacy, which includes the right not to have—

(a) their person, home or property searched;

(b) their possessions seized;

(c) information relating to their family or private affairs unnecessarily required or revealed; or

(d) the privacy of their communications infringed.
To realise every individual’s right to the highest attainable standard of health as provided in the Constitution, attention should be drawn to Article 21(2) on progressive realisation which requires the Kenyan government to ‘take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed under Article 43.’

A step further for a woman in Kenya to enjoy the right to sexual and reproductive health involves the right of access to information. Article 35(1) of the 2010 Constitution address this right. Every citizen has the right to access (a) information held by the State; and (b) information held by another person and required for the exercise or protection of any right and fundamental freedom. I argue that the right to access to information e.g. about abortion and contraception has to be promoted and facilitated. A failure to provide adequate information to help sex workers to make informed decisions that affect their sexual and reproductive health lives, fails to adhere to the international human rights treaties and the spirit of the Constitution for which chapter two’s principles of empowerment and non-discrimination are grounded.

Abortion remains contentious in Kenya and studies have shown as pointed out in chapter one that colonial history in former colonies is ‘part of the explanation for a conservative abortion policy which constitutionally protected the right to life of the ‘unborn’.’ Article 26(4) of the 2010 Constitution permits abortion where ‘in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.’ The same Constitution states that ‘the life of a person begins at conception.’ Marge Berer equates the contentious abortion issue in particular with the way it was handled at the 1994 ICPD Conference. She sees the governments’ actions as a diversion aiming not to address what they should do for a woman who has an unwanted pregnancy and seeks

266 Ibid Article 21(1).
270 Ibid Article 26(2).
abortion services\textsuperscript{272} and further as a call for an increased use of contraception, ‘as if contraception only will eliminate any subsequent poorly managed abortion.’\textsuperscript{273} On abortion, Berer sees the ICPD as seeking to ‘wash their hands of responsibility for the harm that results from unsafe and illegal abortion and that those women living in countries where abortion is unsafe and illegal [majority of who are in the global south] can only hope to be ‘patched up’ after the act.’\textsuperscript{274} Berer points how the provision stating ‘in no case should abortion be promoted as a method of family planning’ has had a major effect on women and their access to safe abortion services\textsuperscript{275} particularly in the global south. These provisions have been used to block safe abortions and threaten funding opportunities, claims Berer.\textsuperscript{276} Although the provisions were a compromise to give the declaration the light of day as Berer avers that such compromise ‘ends up pleasing no one entirely.’\textsuperscript{277} The risk to the lives of women in the global south cannot be overemphasised in the thesis.

Despite challenges in realising rights under the Kenyan Constitution, women in Kenya have been provided with standards against which to hold the government accountable vis-à-vis their sexual and reproductive health rights.\textsuperscript{278} These standards are drawn from international human rights instruments, declarations, UN documents and the Constitution\textsuperscript{279} as this chapter has shown. Celebrating the 2010 Kenyan Constitution, Representative of KESWA acknowledged in her interview during my fieldwork stating that:

\begin{quote}
We are celebrating the Constitution ... because today, whether you are a sex worker, a man having sex with another man or a person who is injecting drugs, we are all counted as one in terms of health. Article 43 says that everybody should get comprehensive treatment ... and everything that is [related to] health.\textsuperscript{280}
\end{quote}

\textsuperscript{272} Ibid.
\textsuperscript{273} Ibid 154.
\textsuperscript{274} Ibid.
\textsuperscript{276} Berer, ‘The Cairo “Compromise” on Abortion and Its Consequences for Making Abortion Safe and Legal’ (n 271) 154.
\textsuperscript{278} C Hayes, ‘Tackling Violence Against Women: A Worldwide Approach’ in G Terry and J Hoare (eds), \textit{Gender Based Violence} (Oxfam GB 2007) 1, 10.
\textsuperscript{279} Ibid.
\textsuperscript{280} Interview with Representative, Kenya Sex Worker Alliance (Nairobi 25 June 2015).
3.4 Conclusion

Human rights are minimum agreed standards that States undertake to adhere to as a matter of choice and as a matter of State sovereignty. This chapter furthers that understanding of the relationship between rights and SRH and their relevance in the daily lives of women who do sex work in the global south. This chapter has demonstrated that international and regional human rights treaties and the Constitution of Kenya 2010 provide a framework within which to address inequality and discrimination and access to SRHR information, including gender-based violence, that have a significant impact on the sexual and reproductive health rights of sex workers in Kenya. It has shown that the government’s conduct towards its women, including sex workers as regards their sexual and reproductive health rights is not an internal or domestic matter but a regional and international one. It has shown that a violation of sexual and reproductive health rights of women is often a breach of international human rights principles and standards. It has argued that meaningful use of HRBAs grounded in the international human rights law reviewed in this chapter, that is, CEDAW, ICESCR and Maputo Protocol ensures that the right to the highest attainable standard of mental and physical health, including sexual and reproductive health is respected, protected and fulfilled for the greater empowerment of women in the country. In the next chapter, I outline the methodology used in my empirical research. The chapter provides detailed ethical considerations undertaken. It illuminates the methods and techniques used to carry out interviews to answer my research questions highlighted in chapter one.

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Chapter Four

Methodology

No matter how carefully one plans in advance, research is designed in the course of its execution.¹

4.0 Introduction

The previous chapters dealt with commitments and potential of rights and chapter five and six address the reality of their impact on policy and the law and they use the primary research interview. This chapter explains the methodology used in my empirical research. Although it has explained the doctrinal and secondary sources used in the study, this chapter primarily deals with the fieldwork. It provides a detailed account of the methods and techniques used to carry out interviews to answer my research questions. I give a detailed account of the ethical considerations I undertook before, during and after the interviews, the participants in the research, an explanation of the method used to collect data and the approach used for analysis.

In section 4.1 I discuss the feminist research methodology of the original empirical research underpinned by the theoretical framework in chapter two, the doctrinal method and secondary sources (in sections 4.2 and 4.3), I present the ethical considerations (in section 4.4) and my positionality as the researcher (in section 4.5). The chapter further discusses the sampling design as well as the data collection techniques I employed (in sections 4.6 and 4.7). In this chapter, I also present how I transcribed the data I obtained from the field including its coding and analysis (in sections 4.8 and 4.9). While in the field, as seen (in section 4.10), I participated in meetings organised by NGOs working with sex workers and on sexual and reproductive health rights which provided me with the current scope in the country. The chapter highlights delimitation and limitations and conclusions (in sections 4.11 and 4.12).

4.1 Feminist Research Methodology

As an interdisciplinary study, my thesis has taken a socio-legal approach, which scholars have argued to be compatible with feminist perspectives, which I also used to carry out my fieldwork through empirical interviews as well as analysis of the data. According to A. Bradshaw,

First, socio-legal research considers the law and the process of law (law-making, legal procedures) beyond legal texts – i.e. the socio-politico-economic considerations that surround and inform the enactment of laws, the operation of procedure, and the results of the passage and enforcement of laws. Second, in studying the context and results of law, socio-legal research moves beyond the academic, judicial and legislative office, the chamber, library and committee room, to gather data wherever appropriate to the problem.

Rebecca Cook asserts that empirical evidence and feminist legal methods can be used to reveal the law’s neglect of women’s sexual and reproductive health and expose legal bias that harms women. Feminist scholars argue that a feminist methodology calls for a look ‘beneath the surface of law to identify the gender implications of rules’. Katharine Bartlett has argued that the woman question is the primary feminist method and that ‘In law, asking the woman question means examining how the law fails to take into account the experiences and values that seem more typical of women than of men, for whatever reason, or how existing legal standards and concepts might disadvantage women.’ The woman question, she argues ‘assumes that some features of the law may be not only nonneutral in a general sense, but also “male” in a specific sense. The purpose of the woman question is to expose those features and how they operate, and to suggest how they might be corrected.’ Without the woman question, Bartlett argues that ‘differences associated with women are taken for granted and, unexamined, may serve as a justification for laws that disadvantage women. The woman question reveals how the

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4 Bradshaw, ‘Sense and Sensibility: Debates and Developments in Socio-Legal Research Methods’ (n 2).
8 Ibid.
position of women reflects the organisation of society rather than the inherent characteristics of women.\(^9\)

In exposing the hidden effects of laws that do not explicitly discriminate on the basis of sex, Bartlett reasons that ‘the woman question helps to demonstrate how social structures embody norms that implicitly render women different and thereby subordinate.’\(^10\) She contends that:

*Asking the woman question does not require decisions in favour of a woman. Rather, the method requires the decision-maker to search for gender bias and to reach a decision in a case that is defensible in light of that bias. It demands, in other words, special attention to a set of interests and concerns that otherwise may be, and historically have been, overlooked. The substance of asking the woman question lies in what it seeks to uncover: disadvantage based upon gender’.\(^11\)

Significantly, Bartlett asserts that ‘asking the woman question confronts the assumption of legal neutrality, and has substantive consequences only if the law is not gender-neutral.’\(^12\)

In particular, examining sex workers’ sexual and reproductive health rights through a feminist transnational lens makes visible the global and local linkages of the law and their impact on daily lives of sex workers.\(^13\) The main focus of the in-depth interviews and focus group was to get the lived experiences of sex workers from their own perspectives. Feminist research is defined by its values and processes, which seek to respect, understand and empower women.\(^14\) It captures women’s lived experiences in a respectful manner that legitimates women’s voices as sources of knowledge.\(^15\) To understand women’s lives, feminist researchers recognise that a variety of methodological techniques are necessary.\(^16\) In particular, qualitative data have been seen as useful in capturing women’s stories and legitimating those experiences as sources of

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\(^9\) Ibid 843.
\(^10\) Ibid.
\(^11\) Ibid 846.
\(^12\) Ibid 847.
\(^15\) Ibid 783.
\(^16\) Ibid.
knowledge and which I have used in the study to enable the voices of sex workers about their experiences and challenges to be heard particularly the circumstances under which their sexual and reproductive health rights are violated.

Feminist researchers argue that just as there is not one feminist theory, so there is not one feminist research method. They argue that feminist research focuses on enlightenment and social change using a variety of methods which have been borrowed from other methodologies, particularly qualitative methods. Feminist research methodology is distinctive from traditional research in a variety of ways: it focuses on gender and gender inequality, on the everyday experiences and viewpoints of women and the use of research methods aimed at exploring these it uses reflexivity as a source of insight and lastly it actively tries to remove or reduce the power imbalance between researcher and respondents. The use of qualitative methods, as opposed to quantitative methods, has been preferred in feminist research, but this does not negate the broad acceptance of both qualitative and quantitative work in feminist scholarship, as notes Rebecca Campbell and Sharon Wasco.

Although Alan Bryman shows that the integration of quantitative and qualitative data has increased in recent years, Bryman also argues that ‘unless there is some rationale for the use of multi-strategy research, there is the possibility of data redundancy, whereby some data are generated which are highly unlikely to shed light on the topic of interest’. This, Bryman further argues, ‘would entail not just a waste of research resources but also a waste of time’. Qualitative methods, as Sara O’Shaughnessy and Naomi Krogman point out, do not only enable women to address the questions that matter most in their lives, they do this in a manner that respects their values, knowledge and subjectivity. Studies have shown that there is a missed opportunity to use

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17 Ibid 784.
19 Ibid.
20 Ibid 24 and 25.
21 Campbell and Wasco, ‘Feminist Approaches to Social Science: Epistemological and Methodological Tenets’ (n 13) 783.
23 Ibid 111.
24 Ibid.
qualitative research to conduct further debates about the generation of knowledge and the role of power in the research process, but methods such as interviews and focus groups are noted to have a strong presence in feminist qualitative research. Some scholars have argued that the distinction between qualitative and quantitative research methods is unclear and problematic and that it is best to discuss the pros and cons of these research methods in the context of specific types of research problems. Qualitative methods are preferred for describing the lived experiences of participants in their own words and not attempting to categorise and quantify experiences. Qualitative data, in Fu-Jin Shih’s view, are a vehicle for studying the empirical world from the perspective of the subject, not the researcher.

4.2 Doctrinal Method

As explained in chapter one, I employed a doctrinal method in the study. In so doing, I analysed international and regional human rights law as well as national laws and policies to establish what the law in relation to human rights and health including sexual and reproductive health is and related changes. For example the UN Convention on the Elimination of All Forms of Discrimination against Women at the international level, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa at the African regional level and the Health Act of 2017 at the national level. I also utilised court cases. This analysis constructed chapters three and four of the study providing answers to questions (a) To what extent have laws and policies adopted a rights-based approach? and (b) What are the mechanisms that promote or deny the enjoyment of sexual and reproductive health rights of sex workers? According to Mike McConville and Wing Chui, doctrinal research ‘focuses heavily if not exclusively upon the law itself as an internal self-sustaining set of principles which can be assessed through reading court judgments and statutes with little or no reference

26 Ibid 516.  
27 CM Allwood, ‘The Distinction Between Qualitative and Quantitative Research Methods is Problematic’ (2012) 46 Quality and Quantity 1417, 1428.  
to the world outside of the law,'\textsuperscript{31} while Terry Hutchinson and Nigel Duncan state that doctrinal research is ‘research into the law and legal concepts’\textsuperscript{32} and they comment further that the ‘doctrinal method is similar to that being used by the practitioner or the judge, except that the academic researcher is not constrained by the imperative to find a concrete answer for a client.’\textsuperscript{33}

\textbf{4.3 Secondary Sources}

Beyond doctrinal analysis as discussed above and in chapter one, I utilised secondary sources in the study\textsuperscript{34} the result of which constructed the background and the theoretical framework and enhanced analysis of the law. I conducted a review of the existing literature to establish the current knowledge on human rights with a focus on women in the global south unravelling the challenges and gaps in the existing research.\textsuperscript{35} The analysis offered information vital to answer the four research questions. I reviewed books from the library and online databases, journal articles, government documents, United Nations and African Union documents, e.g. State Reports and Shadow Reports, non-governmental organisation reports and media reports, as well as Internet sources. For example, I collected recent reports and publications from organisations in Nairobi: the Federation of Women Lawyers Kenya (FIDA Kenya), the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), EACHRights, Centre for Reproductive Rights (CRR) and the Law Society of Kenya (LSK). While some reports contained updates on the current situation of human rights, others specifically addressed the situation of sexual and reproductive health rights in Kenya. To search online databases, I used keywords such as ‘human rights/ law/ based approach’, ‘women and human rights’, ‘sex workers in Africa/ Kenya’, ‘sexual and reproductive health/ rights’, ‘Constitution(s)/ in Africa/ of Kenya’, ‘health and international human rights law’, ‘enjoyment of human rights’, ‘research methods’ and so forth.

\textsuperscript{31} McConville and Chui, ‘Introduction and Overview’ (n 30).
\textsuperscript{32} Hutchinson and Duncan, ‘Defining and Describing What We Do: Doctrinal Legal Research’ (n 30) 85.
\textsuperscript{33} Ibid 107.
\textsuperscript{35} V Braun and V Clarke, ‘Using Thematic Analysis in Psychology’ (2006) 3 Qualitative Research in Psychology 77, 86.
4.4 Ethical Considerations

My methodological approach as discussed in chapter two, required that I put women first in conducting my empirical research in Kenya. Undertaking my fieldwork required that I take ethical considerations into account before, during and after conducting my fieldwork in conformation with the Data Protection Act (1998) in the UK. For guidance on the ethics application process, I attended a ‘Getting Ethical Approval’ workshop offered by the Sussex Doctoral School. Because of the subject matter in my study, my research was identified as high risk and raised ethical issues including how to deal with physical and psychological risks to sex workers and the researcher, informed consent, confidentiality, anonymity and destruction of data. I have addressed them here and in the sections below.

I made an ethical application and obtained approval from the Cluster-based Research Ethics Committee at the University of Sussex approved on 2 December 2014\(^\text{36}\) (see appendix B Ethics Approval Certificate). My research involved an overseas travel safety and security risk assessment. Although I was doing fieldwork in my home country Kenya, traveling warnings had been issued in some parts of the country and I had to provide information travel inform advice to the Ethics Committee. During my fieldwork I ensured that my family members were informed of my whereabouts and I had occasional correspondence with my supervisors and advised them of my progress.

Considering that my study involved vulnerable participants i.e. sex workers and that giving informed consent would be difficult, I used the Bar Hostess Empowerment and Support Programme (BHESP), an organisation working directly with sex workers to recruit them. Given the sensitivity of the topic of discussion, which involved discussion of sexual activity and that the interviews, especially with sex workers, could potentially provoke emotional experiences, particularly when sex workers had to relive their difficult experiences,\(^\text{37}\) I used BHESP who already had and offered counselling services to sex workers, to provide counselling to any of the sex workers who felt distressed, including any delayed reactions of distress\(^\text{38}\) if necessary. It was important that all the participants in the in-depth interviews and focus group discussion give their informed

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\(^{38}\) Ibid 39.
consent (see Appendix C and D: Consent Forms). I obtained informed consent by the participants signing the consent forms. To ensure confidentiality in the focus group, the consent form contained information requiring participants to respect the confidentiality of other participants. The participation of participants was voluntary and I explained to them that they had the right to withdraw at any stage of the interview or focus group without giving reasons. For confidentiality purposes for all the participants including professionals (see E List Coded List of Participants), I used anonymised quotes in the thesis.

4.5 The Researcher’s Positionality

I was born and raised in Kenya, educated in Kenya, India, South Africa and, currently, the UK. I can describe myself as a ‘woman cracked by multiple migrations’,39 I am an African woman who has received both non-Western and Western education. In the conduct of any interview research, feminist scholars observe that, ‘feminists must maintain a reflexive awareness that research relations are never simple encounters, innocent of identities and lines of power, but, rather, are always embedded in and shaped by cultural constructions of similarity, difference, and significance.’40 As an African feminist scholar from Kenya studying at university in the UK, I am in a privileged position. I am warned, as Mohanty notes, that ‘privilege nurtures blindness to those without the same privileges.’41 According to Sylvanna Falcón, ‘privilege requires transnational feminist researchers to be especially aware of the power they wield in the research field and how that power can impact [on] the research itself.’42

Despite being a Kenyan, I am aware that I could be labelled an affluent woman who was privileged to study at a British university.43 I am concerned about what Wendy

Mitchell and Annie Irvine have referred to as ‘the lasting research footprint’, what my research as well as myself as a researcher might leave with participants.\textsuperscript{44} I do not want ‘privilege’ to define whom I am, and my research; thus, establishing a rapport with the participants was important to me. Critics of the concept of rapport argue that it can be manipulative, leading participants to disclose more than what they would have wanted to and have regrets after the interview.\textsuperscript{45} I also recognise Chandra Mohanty’s critique of the Third World middle class and urban scholars who, she notes, ‘write about their rural or working-class sisters and assume their own middle-class cultures as the norm and codify working-class histories and cultures as other.’\textsuperscript{46} This approach, Sylvia Tamale argues, is ‘myopic and dangerous’\textsuperscript{47} and it restricts the framework within which African women can challenge domination.\textsuperscript{48}

With this in mind, I want to set out my position. As stated early on, before starting my PhD, I worked at the Federation of Women Lawyers in Kenya (FIDA Kenya), a women lawyers membership organisation of over 1,000 lawyers and law students, established in 1985 during the United Nations Third World Conference on Women in Nairobi. I joined FIDA Kenya in 2006 as an intern, after completing my Master’s degree in Law in South Africa, and rose to senior positions (Senior Legal/ Programme Officer). I worked in both in Kenya’s main office in Nairobi and the Kisumu regional office. For many years the vision of FIDA Kenya was of ‘a just society free from discrimination against women.’\textsuperscript{49} The adoption of the Kenyan Constitution in 2010, as already pointed out, was one of the organisation’s greatest achievements, particularly because it included several gains that women had fought for decades. The task then was to implement the Constitution. Consequently, FIDA Kenya reviewed its vision to one of ‘a society that respects and upholds women’s rights.’\textsuperscript{50} For more than 30 years the organisation has

\textsuperscript{44} Mitchell and Irvine, ‘I’m Okay, You’re Okay?: Reflections on the Well-Being and Ethical Requirements of Researchers and Research Participants in Conducting Qualitative Fieldwork Interviews’ (n 37) 34.
\textsuperscript{45} Ibid 37.
\textsuperscript{48} Ibid.
\textsuperscript{50} Ibid.
provided legal aid and advocacy for women’s rights at the community, national, regional and international levels.\textsuperscript{51}

For about six years at FIDA Kenya, as a human rights lawyer doing advocacy as well as representing vulnerable women in court, I was exposed to the reality of inequality, injustice, gender-based violence, discrimination and the force of patriarchy. I confronted different human rights violations that women in Kenya, irrespective of their ethnicity, religion, age or marital status, face in their everyday lives in a society that is so engrained with patriarchal attitudes. I represented clients in court and trained women and men on gender and human rights. But the backlash was real. Those of us who worked for the organisation were called all sorts of names: bitter women, men-haters, anti-marriage, lesbians and divorcees, because we confronted patriarchy head-on, challenged the status quo and encouraged women to stand up and speak up! The difficulty was that we were seen as women who taught other women to be hard-headed. My experience taught me to always ask the important question: ‘What about the woman?’

I handled and came across several cases: a married woman whose husband coerced her twice to go to a male relative’s clinic to terminate pregnancies because she already had two deaf children and, according to him, she was, after all, only giving birth to deaf children. She complied with her husband’s demands to save her marriage; a clever, orphaned girl who had completed secondary school and passed with grades good enough to start university. Unfortunately, she could not go to university for lack of tuition fees and demands to take care of her young siblings. Upon the death of her parents, her relatives disinherited them and they were homeless. She became a sex worker to ensure her siblings had food and went to school; a primary-school girl who was on the verge of expulsion from school because she was pregnant, her elder sister had helped her terminate the pregnancy so that she did not drop out of school when she needed to sit for her final primary-school exam. A boy in the same class had impregnated this girl. The principal (male) threatened to report the girl to the police and call the media to expose her, while the boy faced no similar threats. The young girl was shaken and her elder sister was worried that she would end her own life; widows who were evicted from their matrimonial homes by their in-laws because they accused them

\textsuperscript{51} Ibid.
of causing their husbands’ deaths by ‘bringing the disease’ (HIV) to their sons; and a sex worker who, after providing sexual services to a client on military training in a hotel room, he broke the mouth of a bottle, inserted it into her vagina and kicked it. The sex worker suffered in silence and later died from her injuries and infection; another case where a woman was beaten up by her partner. Her body was bruised and swollen but she did not want to report him to the police, neither did she want him to be arrested. She wanted her partner to be ‘talked to’, to stop beating her.

The emotional nature of a lot of the work I undertook at FIDA Kenya meant that I became, in the words of Maggie O’Neill, ‘immersed in the range of differing experiences of women.’ During this time, I helped to conduct a study and document human rights violations of sex workers in Nairobi, Mombasa and different towns in Kenya, followed by further training sessions for sex workers, the impact of which I could tell from this encounter. One mid-morning, I was walking in my hometown when I heard someone call my name loudly. I turned round and saw a sex worker who had participated in the research and subsequently been to the training sessions I conducted. I walked back to meet her. She was with a client. She introduced me to him and immediately said to him: ‘this is the person who has taught me about my rights. Now I know my rights you cannot dare joke with me.’

The women’s struggle in Kenya is no different from that in other parts of Africa, and even the world. Strong women’s organisations have arisen in Kenya and in other African countries to oppose repressive laws and discriminatory practices that have for a long time been resisted. Their campaign for women’s rights include demands for reforms to abortion, prostitution, land and electoral laws and efforts to encourage women to make informed decisions about their bodies and participate in leadership, among other things. I chose Kenya as my case study by virtue of my being a Kenyan, and also due to my advocacy, policy and litigation experience which, over the years, has given me a deep understanding of the issues that particularly concern women and girls in the country. It was an advantage to have worked for FIDA Kenya which has been a

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high profile organisation in Kenya. The participants’ knowledge about FIDA’s campaigns and its support for women’s rights allowed me to build confidence and trust with them.

I used my personal networks to identify sex workers and key informants for this project. At FIDA Kenya, I collaborated with different organisations, e.g. the Reproductive Health Rights Alliance (RHRA), an umbrella body for legal, medical and media organisations working on reproductive health matters, and organisations working with sex workers, including government officials. I further collaborated with many women’s groups including organisations working with sex workers to bring to light the violations and abuse they are subjected to. I developed and nurtured professional networks, which came in handy and helped either to mobilise participants or make references to relevant people who would add value to this research. Essentially, the recruitment of all the participants who added value to this study was done through personal and professional networks and snowballing. For instance the healthcare professional whom I contacted directly was able to link me up with a government official in the Ministry of Health.

4.6 Sampling Design

Commentators have argued that qualitative data is shaped by the samples researchers are able to access and the networks they use to do it. My research topic guided the choice of sampling, particularly hard-to-reach groups, such as sex workers. Purposive and snowballing sampling were used to identify the participants in the study. Also called ‘judgement sampling’, purposive sampling is the ‘deliberate choice of a participant due to the qualities the participant possesses.’ Scholars observe that ‘the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience.’ Snowballing


56 MDC Tongco,‘Purposive Sampling as a Tool for Informant Selection’ (2007) 5 Ethnobotany Research and Applications 147.

57 Ibid.

58 Ibid.
has been described as a method used when the ‘population under investigation is hard-to-reach due to their special characteristics or [the] sensitivity of the study subject.’

I conducted a total of 18 one-to-one interviews and one focus group discussion for this study. Ten female sex workers participated in the one-to-one interviews and seven sex workers participated in the focus group. The pre-determined criteria for sex workers to participate in this study included: women who identify themselves as sex workers and are at least 18 years of age, practising or have practised sex work prior to the interview and willing to participate in the project and share their experiences.

The sex workers were recruited via the Bar Hostess Empowerment and Support Programme (BHESP), an organisation working directly with female sex workers. At BHESP, two programme officers (male and female) with instructions from the Executive Director contacted the sex workers because they work with them and have personal relationships with them. This sample does not claim to be completely representative of all female sex workers in Kenya, considering the various categories of sex workers. But their stories and experiences offer insights into what may not be far from what most other female sex workers encounter in their daily lives, particularly what those from the informal settlements and low-income areas face, including those in other parts of the country and Africa in general. Braun and Clarker have argued that a ‘bigger [sample] isn’t necessarily better’. They argue that there is no formula for a sample size and that researchers often revisit the sample size during data collection.

I interviewed eight professionals. They were: one healthcare professional, one police officer, one policymaker and five representatives from four non-governmental organisations (NGOs). The NGO representatives consisted of one from the Bar Hostess Empowerment Programme (BHESP), one from the Kenya Sex Workers Association (KESWA), two from Family Health Options Kenya and one from the Highway Community Health Resource Centre. Three of these organisations are based in Nairobi, only the Highway Community Resource Centre (‘the Highway Centre’) is based in Mlolongo town, on the outskirts of Nairobi. The Highway Centre provides healthcare services to truck drivers. These truck drivers are the main clients of sex workers in

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61 Ibid 741.
Mlolongo town. It is because of this truck drivers-sex workers relationship that the Highway Centre provides reproductive healthcare services to sex workers in Mlolongo town. Mlolongo provided the uniqueness of a small town on the outskirts of Nairobi. It hosts a weighing bridge, which is commonly associated with long-distance truck drivers who make clients for sex workers.

I identified the professionals because of their knowledge, experience and expertise in sexual and reproductive health rights, and worked either directly or indirectly with sex workers. I first contacted them by telephone and explained the project. Then, I sent them invitation letters by email (see Appendix F and G Recruitment letters for Sex Workers and Professionals) and followed up with telephone calls or further emails and texts to secure interview appointments. Each interview started with an introduction of myself, the purpose of the study and a reminder to the participants that they were free to ask any questions and clarifications before, during and after the interviews. I planned to interview more sex workers and professionals, but this was not possible when I went into the field because of their busy schedules and difficulties in securing appointments; all the interviews were designed to take 45 minutes. I was reminded that ‘no matter how carefully one plans in advance, research is designed in the course of its execution’.

4.7 Data-Collection Methods

In this section I address the empirical methods I used in the research.

4.7.1 Semi-Structured Questionnaire

I conducted in-depth qualitative interviews using a semi-structured questionnaire to answer my research questions. I developed two separate questionnaires for two categories of participants: sex workers and professionals (see Appendix H and I Questionnaires for Sex Workers and Professionals). Each questionnaire contained 10 open-ended questions to be answered by all respondents. While the sex workers shared

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63 Toner, ‘Small is not too Small: Reflections Concerning the Validity of Very Small Focus Groups (VSFGs)’ (n 1).
64 Bell, Doing your Research Project: A Guide for First-Time Researchers in Education and Social Science (n 36) 105.
their experiences and told their stories about accessing sexual and reproductive health and rights, the professionals provided their expertise on the subject. In response to the questions, the shortest interview lasted 15 minutes while the longest lasted 60 minutes. I structured the questions in a way that encouraged the participants to give in-depth accounts of their experiences and left room for probing questions and follow-up questions. This was particularly evident in the responses from the sex workers compared to those from the professionals. This could particularly be linked to the fact that the sex workers were not sure which parts of their own lives to speak about and waited to be guided, while the experts who worked on sex-worker issues got carried away in most cases as they spoke about what they or their offices had done or were doing, and not about themselves. I tested the questionnaire on the focus group first, whom I conducted the first interview with. Listening to the responses in the focus group was a pointer to inform me as to whether their responses were speaking to the questionnaire and, in turn, answering my research question. I collected the qualitative data in three months: May, June and July 2015 and the fifth year of the coming into effect of the Constitution of Kenya (2010). Judith Riley defines data as ‘raw information in any form, such as observation notes or recorded conversations, before analysis.’

4.7.2 Focus Group Discussion

Scholars point out that one-to-one interviews have been widely used in feminist research compared to focus groups. In a focus-group discussion, focus-group interaction is used explicitly as a data-collection method. They involve group discussions. According to Campbell and Wasco:

Bringing women together to discuss their lives brings attention to the myriad of ways gender oppression affects the day-to-day experiences of being female. In fact, for

many women, it is only through their discussions with other women that they are able to find ways to describe the events of their own lives.\textsuperscript{68}

The participants focus collectively upon a topic selected by the researcher and presented to them in different forms, including in a set of questions.\textsuperscript{69} Arguably, this method is useful because it explores people’s knowledge and experiences.\textsuperscript{70} Scholars suggest that it can be used to examine not only what people think but how they think and why they think that way.\textsuperscript{71} A focus group helps to gather information that is less easily accessible in a one-to-one interview, including jokes, laughter, teasing or even argument.\textsuperscript{72} Some participants have found the focus group to be a supportive environment in which to explore their own experiences.\textsuperscript{73} It is seen as a powerful tool with the potential to yield high-quality data to inform the realities of women including sex workers.\textsuperscript{74}

On the other hand, scholars are cautious of focus groups and point out that some voices in the discussion may be silenced while the presence of other participants may compromise the confidentiality of the interview session.\textsuperscript{75} Data collection in a focus group occurs in a group setting and is facilitated by it.\textsuperscript{76} It is argued that sessions in a group setting should be relaxed and that sitting in a circle helps to establish the right atmosphere.\textsuperscript{77} Interactive data is derived from a focus-group discussion.\textsuperscript{78} The participants interact with each other, as well as the researcher.\textsuperscript{79} Jenny Kitzinger comments that ‘a focus group research report that is true to its data should also usually include at least some illustrations of the talk between participants, rather than simply presenting isolating quotations taken out of context.’\textsuperscript{80} Researchers have been criticised

\begin{footnotesize}
\textsuperscript{68} Campbell and Wasco, ‘Feminist Approaches to Social Science: Epistemological and Methodological Tenets’ (n 14) 785.
\textsuperscript{69} Wilkinson, ‘Focus Groups in Feminist Research: Power, Interaction, and the Con-Construction of Meaning’ (n 66) 112.
\textsuperscript{70} Kitzinger, ‘Introducing Focus Groups’ (n 67) 299.
\textsuperscript{71} Ibid.
\textsuperscript{72} Ibid.
\textsuperscript{73} Wilkinson, ‘Focus Groups in Feminist Research: Power, Interaction, and the Con-Construction of Meaning’ (n 66) 115.
\textsuperscript{74} Ibid 112.
\textsuperscript{75} Kitzinger, ‘Introducing Focus Groups’ (n 67) 300.
\textsuperscript{76} Stewart et al., Focus Groups: Theory and Practice (n 62) 19.
\textsuperscript{77} Kitzinger, ‘Introducing Focus Groups’ (n 67) 301.
\textsuperscript{78} Wilkinson, ‘Focus Groups in Feminist Research: Power, Interaction, and the Con-Construction of Meaning’ (n 66) 112.
\textsuperscript{79} Ibid.
\textsuperscript{80} Kitzinger, ‘Introducing Focus Groups’ (n 67) 1995) 302.
\end{footnotesize}
for using focus groups without a clear theoretical framework within which to locate a method of choice.\textsuperscript{81}

Some scholars have noted that the ideal group size should be between four and eight people,\textsuperscript{82} others eight to 12.\textsuperscript{83} Seven sex workers participated in the focus group in this research. All the participants in the focus group (apart from one) did not participate in the one-on-one interviews. The participant who participated in both settings felt she had personal experience she wanted to share in a one-on-one interview. The focus-group discussion started late in the afternoon and lasted for an hour.

Studies inform that a focus group can be conducted in a variety of settings, including homes and offices.\textsuperscript{84} I conducted the focus group in the offices of the Bar Hostess Support and Empowerment Programme, on Jogoo Road in Nairobi. For the convenience of the sex workers, the same female sex workers who participated in the focus group were mobilised to attend the organisation’s donor-review meeting where their transport costs were reimbursed. Stewart and others have stated that a focus group’s participants can be recruited in a variety of ways,\textsuperscript{85} with convenience sampling being the most common method for selecting participants.\textsuperscript{86} Nonetheless, it is argued that as much as this saves time and money, it does not eliminate the need to consider the characteristics of the group.\textsuperscript{87} The intention of virtually all focus groups, as Stewart and others have argued, is to draw some conclusions about a population of interest, and therefore the group must consist of representative members of a larger population.\textsuperscript{88}

I was also invited to attend the organisation’s review meeting, which started at 2.00 p.m. and lasted for about two hours. I learnt to adjust the times at short notice because the scheduled times for these two different events kept changing.

In the focus group, the participants sat in a circle to allow not only eye contact but also create a rapport for interaction between the participants and myself. The rules of engagement in the group were agreed upon, which were mainly: to respect each other’s

\textsuperscript{81} Wilkinson, ‘Focus Groups in Feminist Research: Power, Interaction, and the Con-Construction of Meaning’ (n 66) 113.
\textsuperscript{82} Kitzinger, ‘Introducing Focus Groups’ (n 67) 301.
\textsuperscript{83} Stewart et al., Focus Groups: Theory and Practice (n 62) 37.
\textsuperscript{84} Ibid.
\textsuperscript{85} Ibid 54.
\textsuperscript{86} Ibid.
\textsuperscript{87} Ibid.
\textsuperscript{88} Ibid.
opinions, and what is said in the group remains there. Morgan and Krueger point out that the protection of confidentiality from other members within the group is a major concern. They argue that although the research can reasonably ensure the confidentiality of the official research data, the researcher cannot ensure that other participants in the focus group will not disclose information. They warn that strategies such as asking people not to disclose what they have heard in the group can backfire.

I audio-recorded the discussion and also took a few notes, though I put emphasis on recording, so as to have an ample time to listen to and moderate the discussion. I wanted to make use of the available opportunity with the group as much as possible. Morgan and Krueger rightfully describe the moderator as ‘the instrument’ in a focus-group interview. It is argued that ‘if the moderator, as the data-collection instrument, is not prepared, not attentive or not skilful, then the results will be just as bad as in a poorly prepared questionnaire.’

Kitzinger warns of the hierarchy in a focus group and its potential to affect the data. There is a shift in the balance of power because the research participants gain more control over the interaction than the researcher. Silverman recognises that focus-group data are usually gathered by a moderator offering verbal or visual cues to a small group of people, often chosen to represent a particular sub-group of the population. Stewart et al. argue that there is no appropriate amount of structure for a focus group. I put into perspective the emphasis that the amount of structure and the directness of the moderator must be determined by the broader research agenda that gave rise to the focus group, which entails the type of information sought, the specificity of the information required and how the information will be used.

The participants clearly identified themselves as sex workers. I presented each participant in the focus group with an information sheet (see Appendix J and K Information Sheet for Sex Workers and Professionals) and further explained its contents.

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89 Morgan and Krueger, ‘When to Use Focus Groups and Why’ (n 67) 12.
90 Ibid.
91 Ibid.
92 Ibid 6.
93 Morgan and Krueger, ‘When to Use Focus Groups and Why’ (n 67) 6.
94 Kitzinger, ‘Introducing Focus Groups’ (n 67) 300.
96 D Silverman, Qualitative Research (2nd edn, Sage 2013) 59.
97 Stewart et al., Focus Groups: Theory and Practice (n 62) 39.
98 Ibid.
in Kiswahili. As explained by Stewart et al., clarity helps to set out the expectations of both the group and the researcher.\(^99\) Clarity at the beginning of the interview\(^100\) provides a platform to set out the mission and information required in conformity with it.\(^101\) I also handed each of the participants in the group a consent form and followed up with an explanation of its contents in Kiswahili. They asked questions to confirm their anonymity was guaranteed. I explained to them their right to walk away from the interview if they needed to. All the participants in the focus group consented to continue. They signed consent forms, which I secured in a folder.

I read out the questions on the questionnaire in English and explained them to the group in Kiswahili too. There was no order of response to the questions. Anyone who was ready to speak took the opportunity. The responses then built up in a snowballing process. The more I probed the more the participants freely shared their stories with, as Ripley notes, ‘elaborated and detailed answers’.\(^102\) Some of their stories elicited responses such as group laughter, nodding of heads in agreement, and also changes in their tone. This showed connection among the participants and that they encountered similar, if not the same, experiences. Kitzinger advances that ‘group work can actively facilitate the discussion of taboo topics because the less inhibited members of the group break the ice for shyer participants’ and also ‘participants can provide mutual support in expressing feelings that are common to their group … particularly when researching stigmatised or taboo experiences.’\(^103\) I coded the focus group as ‘focus group discussion’.

### 4.7.3 One-To-One In-Depth Interviews

Individual interviews were in two sets; for the sex workers and the professionals. I conducted one-to-one interviews with 10 sex workers who made specific contributions to them, apart from one who also participated in the focus-group discussion, as pointed out above. One sex worker was particularly smiley but shy to talk, despite the fact that there were only the two of us in the house.

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\(^99\) Ibid.
\(^100\) Ibid 26.
\(^101\) Ibid.
\(^102\) Rapley, ‘Interviews’ (n 54) 15.
\(^103\) Kitzinger, ‘Introducing Focus Groups’ (n 67) 300.
I held interviews with sex workers in two different sex workers’ houses in Korogocho and in Kariobangi for the convenience of the participants. The initial plan was for sex workers to come to the Bar Hostess Empowerment and Support Programme Office on Jogoo Road. However, while on my way to the BHESP offices, I received a phone call from the mobiliser informing me of a change of plan. I adjusted immediately and agreed to meet the mobiliser at a designated place in Kariobangi. Considering the time of day, most sex workers were either still asleep, having come from work, or had just woken up. The mobiliser assured me that she had already talked to the sex workers and they were expecting me. I arrived at the place we had agreed to meet and waited for her. When she arrived I made it clear to her that this project was not funded at all, just in case the sex workers had any financial expectations. She informed me that, from experience, sex workers get tired of people coming to speak to them and when they are not reimbursed they think it is their organisation that gets paid or benefits, instead of themselves.

I conducted the interviews between 11 a.m. and 6 p.m. (East African Time). The mobilisation officer did not sit in on the interviews but remained with me throughout the interviews in Korogocho and Kariobangi, which also gave the sex workers reassurance that their organisation knew about this project. These interviews were done in the sex workers’ houses: six interviews in one sex worker’s house in Korogocho and the other four in another sex worker’s house in Kariobangi. In Korogocho, we shared the tiny space in a corridor with ducks and chickens and children running up and down. A male neighbour played music loudly. Most of the sex workers had just returned from work in the morning hours and were between getting up from their sleep and looking forward to preparing some food for their children and going back to work. All the one-on-one interviews with sex workers were coded from ‘sex worker 1’ to ‘sex worker 10’.

Respondents made the selection of places for interviews. For various reasons including convenience, I held interviews with professionals in their respective offices, the KESWA interview was held at a Java Café on Thika Road because of their small office where an interview would have interfered with the work of the rest of the team members. The interview with the Bar Hostess Empowerment and Support Programme was conducted at the Progressive Bar and Restaurant in Kasarani, near their offices. This bar is significant because it is where the organisation was conceived. The interview was in mid-morning and like most bars, it was quite empty at the time. This
bar is a family business where the respondent worked too. She started her interview by telling me a background story of how paying particular attention to women and girls issues of those who worked in this bar started and led to the existence of BHESP as an organisation. I held the interview with the healthcare professional in his clinic, with the police in a hotel in Nairobi, and a final one in the offices of the Highway Health Resource Centre and Family Health Options Kenya. Generally, the places for interviews were convenient for the participants but also safe spaces within the vicinity of their work spots or private homes in the case of sex workers. These locations created a suitable atmosphere for sex workers to freely share their private and personal stories. During my fieldwork, the President of the United States, Barak Obama, visited Kenya, which resulted in the closure of roads and grounded transport within the city. My interview with the policymaker was unfortunately scheduled on the day of his arrival, hence the telephone interview with her.

4.7.4 Informed Consent from Professionals

All the professionals gave their informed consent by signing a consent form apart from the representative of the Division of Reproductive Health in the Ministry of Health who gave oral informed consent on the telephone before the start of the interview. The phone interview was recorded too, as explained below. Although I later forwarded to the policymaker a consent form by email to sign and return, I did not hear back from her. However, oral informed consent has previously been obtained in a similar study with female sex workers. Just like with the consent forms from the sex workers, I secured these in a folder and proceeded with interviewing. The participants were coded so as not to show their real names, e.g. the policymaker was coded as ‘Representative of the Division of Reproductive Health’. While the organisations were named because of the work they do, the names of the individuals from those organisations were not used in this study, they were instead coded as ‘representative of KESWA’ and so forth.

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105 Ibid 444.
4.7.5 Audio-Recording

Julia Bailey argues that taking notes instead of audio-recording is not sufficiently accurate or detailed for most qualitative projects.\(^\text{107}\) I recorded all the interviews in this study. According to Judith Bell, audio-recorded interviews can be useful to ‘check the wording of any statement you might wish to quote and to check that your notes are accurate. They can also be useful if you are attempting some form of content analysis and need to be able to listen several times in order to identify categories.’\(^\text{108}\) I made it clear to the respondents why recording was important during the interviews. I addressed their concerns; for example, one sex worker wanted to know whether I was taking photographs because she did not want to be photographed, especially because her family did not know that she was a sex worker. All the participants agreed to their interviews being recorded by signing consent forms. I did the audio-recording on my iPhone 4, which recorded the date, month and year, and also the length of the interview. To confirm that the interview was properly recorded, after an interview, I quickly played some parts of the interview in the presence of the respondent. I left the place of the interview or moved on to the next interview with the reassurance that I had obtained the necessary data.

I later copied all the files onto my computer for safety and backup. As indicated earlier, recording interviews gave me ample time to interact with the interviewees, rather than spending time concentrating on listening and writing at the same time.\(^\text{109}\) It nevertheless provided me with a more detailed account of our conversation than I would have if I did take notes or tried to reflect.\(^\text{110}\) Importantly, I could replay the audio.\(^\text{111}\) The recordings did not only capture their statements but also the fluctuations in their voices when explaining themselves, which informed what they felt at that point. In some instances, I took a few notes, particularly on points that interviewees made and that I wanted to return to, more so in the focus group, given that participants would sometimes build up on each other’s points.

\(^{108}\) Bell, Doing your Research Project: A Guide for First-Time Researchers in Education and Social Science (n 36) 140.
\(^{109}\) Rapley, ‘Interviews’ (n 54) 18.
\(^{110}\) Ibid.
\(^{111}\) Ibid.
4.8 Transcription of Verbal Data

Some scholars have found transcription to be an important early stage of data analysis, while others argue that it is in fact the first step in analysing data. It is an interpretive process, which involves making judgements. I personally recorded and transcribed the interviews from verbal into written form. My data were mainly verbal and transcribing depended mostly on the length of the talk. I transcribed all the interviews in the months of August and September 2015. Most of the interviews with the sex workers were a mixture of Kiswahili, slang and a bit of English. Because I speak and understand these languages, I translated the transcripts into English myself in preparation for data analysis. The data generated 19 transcripts, including the focus group. For the purposes of owning and personalising the data, I preferred to transcribe the raw data manually, and therefore no software was used. An attempt to use Google translation resulted in completely different interpretations of what the participants either said or meant, and therefore it did not work for my research. Maintaining the original meanings of the words used by all the participants in the interviews was vital. As I listened to the audio, my memory was taken back to the moments when the interviews were conducted. Arguably, it is impossible to represent the full complexity of human interaction in a transcript; however, as Julia Bailey comments, ‘listening to and/or watching the ‘original’ recorded data brings data alive through appreciating the way that things have been said as well as what has been said.’

4.9 Coding Data and Analysis

Guided by my feminist theoretical framework, I used a thematic analysis approach to identify and interpret key features of my data. Virginia Braun and Victoriana Clarke argue that for evaluation to be provided on research, the said research has to provide clarity on its analysis process. Before analysing my research data, I attended Nvivo, a qualitative analysis-software program to code data, training in November 2015 provided

112 Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 88.
113 Bailey, ‘First Steps in Qualitative Data Analysis: Transcribing’ (n 107) 130.
114 Ibid.
115 Ibid 129.
118 Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 80.
by the Sussex Doctoral School at the University of Sussex. The training included setting up a project, importing documents and creating attributes.\(^{119}\)

However, my data set was not too large and instead I did manual coding and manual in-depth analysis, identifying common recurring themes from the responses given by the respondents. Codes are the smallest units of analysis or the building blocks of themes.\(^{120}\) Themes, as scholars have stated, provide a framework for organising as well as reporting analytic observations.\(^{121}\) Braun and Clarke argue that themes should be conceptualised as ‘diamonds waiting to be discovered’.\(^{122}\) Themes represent some level of ‘patterned response or meaning within data set’.\(^{123}\) I made my own judgement on what the themes were.\(^{124}\) During the analysis I went through what is called a ‘recursive process’.\(^{125}\) This involved reading and rereading my data set.\(^{126}\) This process is said to be the bedrock of analysis.\(^{127}\) Virginia Braun and Victorian Clarke define a data extract as ‘an individual coded chunk of data, which has been identified within, and extracted from, a data item’\(^{128}\) and a data item as ‘each individual piece of data collected which together make up the data set.’\(^{129}\)

Having prepared for the interviews, conducted and transcribed them, and finally conducted the analysis, it created a close relationship between myself and my data. Often, the experience took me back to the points at which the interviews were conducted. The data is presented mainly in chapters five and six.

Braun and Clarke note that thematic analysis is widely used, but there is no consensus on what it means and how to go about it.\(^{130}\) Thematic analysis can be used to analyse both large and small data sets, as small as 1–2 participants for homogenous samples.\(^{131}\) Braun and Clarke refer to thematic analysis as a ‘method of identifying, analysing and

\(^{119}\) L McDonnell, ‘Qualitative Data Analysis Using Nvivo 10: Course Manual’ (Department of Sociology University of Sussex 2013) 6 and 14.
\(^{120}\) Clarke and Braun, ‘Thematic Analysis’ (n 117) 297.
\(^{121}\) Ibid.
\(^{122}\) Braun and Clarke, ‘(Mis)conceptualising Themes, Thematic Analysis, and Other Problems with Fugard and Potts’ Sample-Size Tool for Thematic Analysis’ (n 60) 742.
\(^{123}\) Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 82.
\(^{124}\) Ibid.
\(^{125}\) Ibid 86.
\(^{126}\) Ibid.
\(^{127}\) Ibid 87.
\(^{128}\) Ibid 79.
\(^{129}\) Ibid.
\(^{130}\) Ibid.
\(^{131}\) Clarke and Braun, ‘Thematic Analysis’ (n 117) 298.
reporting patterns (themes) within data\textsuperscript{132} and that it can be applied across a range of theoretical frameworks.\textsuperscript{133} They argue that thematic analysis has one key advantage, and that is flexibility.\textsuperscript{134} This flexibility is particularly related to the research questions, sample size and constitution, the data-collection method and the approaches to meaning generation.\textsuperscript{135} As required of theoretical research, I conducted a literature review prior to conducting analysis.\textsuperscript{136} Braun and Clarke’s step-by-step guide to conducting thematic analysis and their 15-point checklist of criteria for good thematic analysis (see Appendix L: A 15-Point Checklist of Criteria for Good Thematic Analysis) were useful for answering my research question and my theoretical focus. They provide six phases of thematic analysis: familiarising yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and lastly producing the report.\textsuperscript{137}

4.10 Participation in Other Meetings

While in the field I was invited to two different meetings by the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) Technical Working Group and the Bar Hostess Empowerment and Support Programme.

The value of these meetings for me was to get up to speed with current events in sexual and reproductive health rights in Kenya. At KELIN’s meeting, I participated as a guest expert. KELIN had developed draft brochures on sexual and reproductive health rights as well as a draft Police Manual on Sexual and Reproductive Health and Rights. The Technical Working Group met to make contributions to the draft documents and I gave my input to these documents, too. KELIN is an organisation which advocates for not only the protection and promotion of HIV-related human rights but also the sexual and reproductive health of women, including sex workers.\textsuperscript{138} It is also a member of the Reproductive Health and Rights Alliance (RHRA), which is an alliance of several organisations drawing together different expertise from legal to medical, media etc. It

\textsuperscript{132} Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 79.
\textsuperscript{133} Clarke and Braun, ‘Thematic Analysis’ (n 117) 297.
\textsuperscript{134} Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 78.
\textsuperscript{135} Clarke and Braun, ‘Thematic Analysis’ (n 117) 297.
\textsuperscript{136} Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (n 35) 86.
\textsuperscript{137} Ibid 86-93.
recognises the uniqueness of bringing like-minded organisations to work together to advance sexual and reproductive health rights in Kenya by speaking with authority as one voice. While medical organisations such as the Kenya Obstetrical and Gynaecological Society and the Kenya Medical Association address the medical implications, legal organisations such as KELIN and the Federation of Women Lawyers Kenya address the legal implications, and media-related organisations deal with the packaging of the right information for the public. The second meeting was held by the Bar Hostess Empowerment and Support Programme (BHESP), an organisation which advocates for quality health services and human rights awareness to women sex workers in Kenya.\textsuperscript{139} As aforementioned, this meeting helped me not only to understand the strides sex workers have made to date in advocating for their rights, but also to understand from the horse’s mouth the challenges that they still faced, including their efforts in engaging with development partners.

\section*{4.11 Limitations and Delimitations}

While I embarked on the fieldwork trip with all preparations in place, my experience was not without challenges. The challenge that I encountered involved getting appointments scheduled, considering the busy schedules of the professionals. My focus group coincided with the BHESP meeting because they also did not want to keep asking sex workers to come to their offices for meetings. To deal with this I was persistent in following up my emails with calls and texts as reminders and adjusted to the time that respondents were available for interviews. Equally, conducting fieldwork as a self-funded student with limited resources can be quite expensive considering all the logistics. However, partial scholarships from Modern Law Review and the School of Law, Politics and Sociology reduced the burden. Notably, during my fieldwork I was faced with concerns relating to male sex workers and their challenges. However, given the feminist focus of this study, that is, targeting women who do sex work, I did not prioritise them.

\textsuperscript{139} Bar Hostess Empowerment and Support Programme (BHESP) &lt;www.bhesp.org/&gt; accessed 2 March 2015.
4.12 Conclusion

In this chapter I have set out the methodology and techniques used to obtain data for this study, including my positionality as the researcher. I have demonstrated that, as a feminist researcher, using a feminist research methodology was necessary to collect the voices and experiences of sex workers in the study. I have given a detailed account of how I went about identifying the participants who participated in this research, the data-collection process, the methods I used and why those methods are relevant for my study. I have explained my data-analysis process and how I obtained informed consent from different participants. I have provided information on ethical considerations before, during and after the fieldwork, which I took into account in conformity with the rules, regulations and procedures to deliver this thesis. Importantly, I have provided a detailed account of the methods and techniques used in the thesis to answer my research questions. I hope that this research will contribute to the realisation and advancement of a rights-based approach to the issues that generally affect women in Africa, especially sex workers. We now move to chapter five where I provide a critical analysis of the Kenyan national context significant for understanding the application of Kenyan laws and policies domestically. I identify and critically review the health-related legislative and policy framework to interrogate the extent to which the provisions of CEDAW, ICESCR and the Maputo Protocol are translated into local laws and policies and the extent to which they enable sex workers to enjoy sexual and reproductive health rights.
Chapter Five

Application of Laws and Policies in the Kenyan Context

... in terms of targeting the policies, we are really stressing a rights-based approach. So I know now what will follow suit is how to implement that [HRBA] ... ¹

Sometimes even a sitting government whenever they see people coming out strongly advocating from a rights-based perspective, they look at them as threats.²

5.0 Introduction

The international discourse of human rights have influenced policy making and programming for SRH and this, it is argued, has permeated national and local debates and practices.³ Several countries in the global south Kenya included, are making efforts to address the underlying causes of women’s ill health through comprehensive laws that require the elimination of discriminatory and stereotyping practices and provide a range of sexual and reproductive health and other services.⁴ In Kenya, the national protection of health, that include sexual and reproductive health rights as defined by international human rights law and the Kenyan Constitution of 2010, derives its legal force from the incorporation of CEDAW, ICESCR, the Maputo Protocol and constitutional provisions into domestic law.⁵ The use of postcolonial feminist theory in the study helps to expose injustices against sex workers and how they are tolerated in Kenya as in other African countries. Sections 5.1.5, 5.2.1, 5.2.2 and 5.2.3 as well as sections 5.1.1, 5.1.2, 5.1.3 and 5.3 of this chapter contributes to answer to these research questions ‘to what extent have laws and policies adopted a rights-based approach?’ as well as ‘what are the mechanisms that promote or deny the enjoyment of sexual and reproductive health rights of sex workers?’

The right to sexual and reproductive health and other health-related rights are addressed within different legislative and policy frameworks. Apart from the Constitution of

¹ Interview with the Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
² Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).

To interrogate the legislative and policy environment in Kenya and examine the extent to which it aligns with the 2010 Constitution and its international human rights obligations to ensure the enjoyment of and the sexual and reproductive health of sex workers, this chapter critically discusses three laws, i.e. the Code, the law on sexual offences and the recently enacted health law, as well as three policies on general health, reproductive health and adolescents. Section 5.1 of the chapter analyses the legislative environment affecting the sexual and reproductive health rights of sex workers in Kenya. In this section, I address the current legislative environment, showing the protections and gaps available in the application of the law to protect the sexual and reproductive health rights of sex workers in Kenya. Specifically, the section addresses the regulation of sex workers (in section 5.1.1), abortion and its legal position (in section 5.1.2) and protections against sexual offences, e.g. the exploitation of sex workers (in section 5.1.3), including different perspectives on the debate to criminalise the demand for sexual services (in section 5.1.4) and lastly, and more significantly, section 5.1.5 reviews the new health law in Kenya.

Section 5.2 examines the policy environment affecting sexual and reproductive health rights in Kenya. This section reviews three key policies, revealing the extent to which they govern the sexual and reproductive health rights of women, including sex workers, in Kenya, but also their assertion of a rights-based approach and what it means in

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6 Penal Code Chapter 63 (Kenya).
7 Health Act 2017 (Kenya).
8 Sexual Offences Act 2006 (Kenya).
10 Prohibition of Female Genital Mutilation Act 2011 (Kenya).
11 Protection Against Domestic Violence Act 2015 (Kenya).
12 Counter Trafficking in Persons Act 2010 (Kenya).
13 Kenya Health Policy 2012-2030 (Kenya).
14 National Reproductive Health Policy 2007 (Kenya).
15 National Adolescent Sexual and Reproductive Health Policy 2015 (Kenya).
16 Kenya Vision 2030 (Kenya).
practice in terms of the enjoyment of sexual and reproductive health rights. They are: the Kenya Health Policy 2012–2030 (in section 5.2.1), the National Reproductive Health Policy 2007 (in section 5.2.2) and the recently reviewed National Adolescent Sexual and Reproductive Health Policy 2015 (in section 5.3.3). Section 5.3 analyses obstacles to the enjoyment of sexual and reproductive health rights for women, and especially sex workers. Finally, the chapter draws a conclusion (in section 5.4).

5.1 The Legislative Environment Affecting Sexual and Reproductive Health Rights

Chapter one has shown that the colonial role of shaping law and policy in Kenya and other former British colonies in different countries in the global south cannot be ignored. For example, that the law has never defined prostitution and prosecution has disproportionately focused on the woman and not the male.\(^\text{17}\) Although allowed under certain circumstances, abortion in Kenya and much of the global south is emotive issue burdened with stigma and hangover from the inherited legal system. Thus, feminist legal theory utilised in the thesis brings women’s experiences into discussion while exposing the male bias.\(^\text{18}\) In this section I consider the current legislative environment in Kenya, showing the protections and gaps available in the application of the law to protect the sexual and reproductive health rights of women who do sex work. Specifically, the section explores the regulation of sex workers, abortion services and protections with regard to the exploitation of sex workers, including different perspectives on the debate to criminalise demand and, significantly, reviews the new health law in Kenya.

5.1.1 Criminalised Sex Workers’ Environment

The government of Kenya identifies sex workers as a key population and defines ‘key population’ as ‘groups who due to specific higher risk behaviour, are at increased risk of HIV, irrespective of the epidemic type or local context.’\(^\text{19}\) The key populations in Kenya


include men who have sex with men, people who inject drugs and sex workers. The Kenyan government acknowledges that legal, cultural and social barriers exacerbate the key populations’ vulnerability to HIV even as the Kenyan Constitution and conventions and covenants guarantee sex workers’ right to sexual and reproductive health rights and other related human rights, as we have seen in chapter three. However, the criminal status of sex work in Kenya has been used to legitimise the mistreatment of sex workers and to support an apparent widespread acceptance among the general public that such conduct towards these women is justifiable. Although, on the face of it, the law governing sex workers in Kenya seems to target both male and female sex workers as discussed below, in reality, female sex workers are likely to be the focus of the law more than their male counterparts. When I asked the policy maker why sex workers in Mlolongo operated freely in their sex dens even with the police around the corner, while those in Nairobi were often arrested, the response showed the lack of legal clarity to even the people who are tasked to make policies in Kenya.

... I am very unclear about the law on sex work. I know when I see the police rounding up the sex workers they make it sound illegal which is also part of the reason that they say they are a vulnerable population. But then a lot of groups promote the health of sex workers, which is... the legal part that I have not really understood. But as health workers we are not there to judge, you know... In terms of legal I am also just as confused. I am not sure about the legal aspect. I think... a lot of people leave alone the sex workers don’t know their rights. A lot of us even who are educated don’t know our rights. And that’s why I was asking what’s the legal aspect because at some point the police will round up the [sex workers]... You know the very people... are violating the rights of the sex workers then we expect that the

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20 Ibid. In its Strategic Direction 8: Promoting Accountability Leadership for the Delivery of the KASF Results by all Sectors– it provides that:
‘KASF takes due cognizance of the constitutional provisions in Constitution of Kenya Article 10 which amongst others, stipulates the obligation by the State and non-state actors to espouse values and principles which amongst others, “...guarantee right to human dignity, equity, social justice, inclusiveness, human rights, non-discrimination, protection of the marginalised”. This provision does not envisage exclusion of any population from enjoying this rights and thus essentially outlaws exclusion of key populations from health care access and participation in related decision making thereof”.


23 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
sex workers will complain about sexual assault? You know those are the things that are such grey areas ... One thing we could do and ... if we could do it perfectly it would be, advocacy and ensuring information is out there for both the police - the law enforcement, the sex workers and the community. I really feel if we could get that information out and get some interactive forum that to me would be the epitome of achieving a lot of things in Kenya because civil education, understanding of the rights ... not just for health almost everything, is still a bit shaky. It’s one of our gaps. I know we have a communication strategy as a government but now we haven’t addressed a lot of things like the legal rights.24

Evidence has shown that despite all these laws, the number of sex workers is on the increase in different countries and if these laws were designed to reduce or curb prostitution, they have failed to do so.25

Historically, criminal law has addressed sex work through criminalising the selling of sexual services, with the imposition of penalties on sex workers themselves and through the criminalisation of various practices around sex work.26 The non-criminalisation of actual sex work in many instances tend to be only technical as sex work can hardly be engaged in without infringing at least one of the surrounding acts that prohibit certain practices.27 Overs and Hawkins point out that these practices include keeping a brothel; recruiting for or arranging the prostitution of others; living off the proceeds of sex work; solicitation; and facilitating sex work through the provision of information or assistance.28 They consider that although selling sex is not directly criminalised in many countries worldwide, there are widespread reports that sex workers are nonetheless treated as criminals when activities around sex work itself are criminalised, or through the use of pre-existing laws to harass, intimidate or justify the use of force against sex workers.29

Early studies show the way the Indian Penal Code was transferred from India to Kenya and other former British colonies and while some of these laws have to date been amended and revised, Henry Morris argues that the basic homogeneity remains.30

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24 Ibid.
27 Ngwena, ‘Sexual Health and Human Rights in the African Region’ (n 22) 231.
28 Overs and Hawkins, ‘Can Rights Stop the Wrongs? Exploring the Connections Between Framings of Sex Workers’ Rights and Sexual and Reproductive Health’ (n 26).
29 Ibid.
Prostitution is commonly understood to be illegal but the law in Kenya does not define prostitution neither does it criminalise it per se.\textsuperscript{31} The provisions of both the Penal Code and the Sexual Offences Act (2006) do not criminalise the practice of sex work in and of itself,\textsuperscript{32} the activities around sex work are criminalised\textsuperscript{33} and brothels as well as use of any house for sex work is outlawed.\textsuperscript{34} In this context human rights violations in relation to sexual and reproductive health continue to occur in the face of Kenya’s comprehensive and ‘rights-based’ Constitution\textsuperscript{35} including the ratification of core human rights instruments as analysed in chapter three. In a joint shadow report to the CEDAW Committee, FIDA Kenya and the Centre on Housing Rights and Eviction (COHRE) with ten other organisations,\textsuperscript{36} informed the Committee at its 48th Session that while the Penal Code did not explicitly define ‘prostitute’, it none the less refers to a woman who in the long run suffers the consequences of the discriminatory legislation.\textsuperscript{37} It is clear that this law affects female gender differently. In fact it fosters inequality and undermines the rule of law as described in chapter two section 2.1.1 and vital in human rights-based approach. The organisations drew the CEDAW


\textsuperscript{32} Ibid 9.

\textsuperscript{33} Ngwena, ‘Sexual Health and Human Rights in the African Region’ (n 2) 231.

\textsuperscript{34} Penal Code Chapter 63 (Kenya), Sections 155 provides that ‘If it is made to appear to a magistrate by information on oath that there is reason to suspect that any house or any part of a house is used by a woman or girl for the purposes of prostitution, and that any person residing in or frequenting the house is living wholly or in part on the earnings of the prostitute, or is exercising control, direction or influence over the movements of the prostitute, the magistrate may issue a warrant authorising any police officer to enter and search the house and to arrest such person,’ while Section 156 states that: Any person who – (a) keeps or manages or assists in the management of a brothel; or (b) being the tenant, lessee or occupier, or person in charge, of any premises, knowingly permits the premises or any part thereof to be used as a brothel; or (c) being the lessor or landlord or any premises, or the agent of the lessor or landlord, lets the same or any part thereof with the knowledge that the premises or some part thereof are or is to be used as a brothel, or is wilfully a part to the continued use of the premises as a brothel, is guilty of a felony.

\textsuperscript{35} D Learmonth, S Hakala and M Keller, “‘I can’t Carry On Like This”: Barriers to Exiting the Street-Based Sex Trade in South Africa’ (2015) 3 Health Psychology and Behavioural Medicine 348 DOI: 10.1080/21642850.2015.1095098.

\textsuperscript{36} Aids Law Project (ALP) Fahamu Kenya; Association of Women in the Media Network in Kenya (AMWIK); Centre for Education and Awareness Creation (CREAW); Gay and Lesbian Coalition of Kenya (GALCK); Groots Kenya; Helpage Kenya; International Commission of Jurist – Kenya (ICJ-K); Tomorrow’s Child Initiative (TCI); Women Empowerment Link (WELL); and Woman Kind Kenya.

Committee’s attention to the Penal Code as a tool used to criminalise feminised poverty and the unequal protection it exhibits between men and women.38

Discriminatory law against sex workers has been challenged in court in South Africa. In a 2002 landmark case, S v Jordan and Others,39 the South African Constitutional Court was tasked to determine the constitutionality of the provisions (sections 2, 3(b), 3(c) and 20(1)(aA)) of the Sexual Offences Act No. 23 of 1957 for criminalisation of sex work and related activities. The court rejected the arguments to challenge discrimination in sex work particularly that a law that criminalised sex work but left the clients unpunished, unfairly discriminated against women.40 This court failed to consider that sex work has a vast majority of women. Scholars such as Ngwena have argued that a rule, policy or practice that is facially neutral but impacts disproportionately and adversely on a particular group that is otherwise entitled to equal protection from discrimination is, indirect discrimination.41

Section 153 of the Penal Code provides that:

1. Every male person who-
   (a) knowingly lives wholly or in part on the earnings of prostitution; or
   (b) in any public place persistently solicits or importunes for immoral purposes, is guilty of a felony.

2. Where a male person is proved to live with or to be habitually in the company of a prostitute or is proved to have exercised control, direction or influence over the movements of a prostitute in such a manner as to show that he is aiding, abetting or compelling her prostitution with any other person, or generally, he shall unless he satisfies the court to the contrary be deemed to be knowingly living on the earnings of prostitution.

Section 154 specifically states that:

Every woman who knowingly lives wholly or in part on the earnings of prostitution, or who is proved to have, for the purpose of gain, exercised control, direction or influence over the movements of a prostitute in such a manner as to show that she is aiding, abetting or compelling her prostitution with any person, or generally, is guilty of a felony.

The lasting consequences of the colonial policies on sex workers and on sexual and reproductive health and rights have to be acknowledged and such laws must be

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38 Ibid.
39 S v Jordan and Others (Sex Workers Education and Advocacy Task Force and Others as Amici Curiae) 2002(6) SA 642 (CC); 2002(11) BCLR 1117 (CC).
40 Ibid [9].
41 Ngwena, ‘Sexual Health and Human Rights in the African Region’ (n 22) 230.
challenged. In a 2002 Parliamentary debate, a Member of Parliament pointed out the absurdity of the prostitution law in Kenya arguing that it criminalised living on the earnings of prostitution and distinctively targeted women.42 The following excerpt from the Hansard provides insight on the debate on sex work law in Kenya:

Mr. Muite:

…

This law is to do with prostitution. If you are amending this law, let the Attorney-General criminalise prostitution itself because it remains legal in this country. There is no offence in prostitution, but if you procure a woman to become a prostitute, you have committed an offence. If you are loitering for immoral purposes, you are committing an offence. We are going round in circles. Why do we criminalise prostitution? When you criminalise it, have the balance right.

If you go to Makadara or Kibera law courts, you will find that it is women who are being charged with prostitution. They do not commit prostitution, procure or loiter on their own. It is a market demand and supply. If there is no demand, there is no prostitution. These women do not commit prostitution amongst themselves. Men are also involved. You will never find men being arrested or being told to go and be checked by a doctor. If you go to Central Police Station now, you will find a group of women who have been locked up there and who will be inhumanly taken to Kenyatta National Hospital to be medically examined as to whether they are spreading venereal diseases. Where are the men that actually demand the services of prostitution?

Let us not enhance this sentencing while still skirting around the issue of prostitution. It is either legal or illegal. We should not just go criminalising the peripheral issues without touching on the actual issue. When you say it is serious offence if you secure a woman to leave Kenya to become a prostitute outside Kenya; that is her decision …

The world has become a global village. Open up everything. Let our prostitutes go and compete with their prostitutes in those countries…

The Temporary Deputy Speaker (Mr. Sungu): Mr. Muite, you are not promoting immorality by suggesting that?

Mr. Muite: Mr. Temporary Deputy Speaker, Sir, you know there are countries like Holland and Norway where prostitution is legalised. They are called commercial sex workers. They are not even called prostitutes. They use consumer friendly language. If it is legalised there, why do we want to make it an offence for a woman to go and do these things where they are actually legalised?

The Attorney-General (Mr. Wako): On a point of order, Mr Temporary Deputy Speaker, Sir. Could the hon. Member disclose his interest in this matter of sexuality? He is an advocate and I am begging to wonder whether he has received instructions to register the Association of Prostitution in Kenya and also to plead for the legalisation of prostitution in Kenya along the line of what is going on in Scandinavian countries.

Mr. Muite: Mr. Temporary Speaker, Sir, we have not perhaps reached the stage where we can legalise prostitution here. I am pointing out the contradiction in the proposed amendment by the Attorney-General; that if you facilitate a prostitute to go out, you

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42 Hansard, Kenya National Assembly 3 October 2002, cols 2341-42
are committing an offence here and she is going out to engage in commercial sex work in a country where this act is legalised. I was not just talking about the prostitutes. I was mentioning prostitution because the sections here deal with immorality. I was pointing out the hypocrisy of the law as it is. The Attorney-General has not gone far enough. He is still skirting around the issues. Prostitution is not an offence. Why do you make it an offence in this country? If you live on the earnings of prostitution, you are committing an offence, but if you indulge in prostitution, you have not committed an offence. These are the contradictions and hypocrisies we are talking about.43

In reality, sex workers in Kenya are often arrested under County by-laws. They are rounded up in the streets and forcefully tested for HIV and threatened with prosecution for spreading the disease.44 The colonial legislative legacy that granted powers to arrest and subject sex workers to medical tests as examined in the work of Bartley in chapter one, is still perpetuated even when the 2010 Constitution promises non-discriminatory treatment. It is an offence under general nuisance of Nairobi by-laws to loiter, importune or attempt to procure a female or male for prostitution.45 In Mombasa County, Sections 258 (m) and (n) of its by-laws of 2003 provide that ‘any person who shall in any street or public place, loiter or importune for the purpose of prostitution, procure or attempt to procure a female or male for the purpose of prostitution or homosexuality shall be guilty of an offence.’46

Criminalisation increases the threat to life of sex workers and other key populations. Sex workers in different parts of the country have lost their lives in the hands of their clients or criminals;47 a clear violation of the very principles of human rights guaranteed

43 Ibid.
in international and regional human rights treaties to which Kenya is a party as discussed in chapter three. The murderers of these women are rarely brought to justice because investigations are not properly done or lack of evidence often influenced by the criminalised environment in which sex workers operate.\textsuperscript{48} The handful prosecutions, for example, in the case of \textit{Republic v Moses Gitonga Macharia},\textsuperscript{49} where the client of a sex worker strangled her to death in a hotel in Nyeri and was convicted to death, have hardly served as a lesson to the violators of human rights including sexual and reproductive health rights of women in sex work. Sex workers continue to be killed indicating the impunity for violence against sex workers in Kenya even with a progressive Constitution in place as discussed in chapter three. If these rights are translated into lived experiences then they will only be ‘ornaments’ as Merry noted in chapter two.

Punitive laws are said to corrupt the police and make it harder for sex workers to get access to healthcare and the legal system.\textsuperscript{50} For a long time, the police, who are sworn to protect people from violence, have been largely negligent when it comes to people who are seen as powerless, such as sex workers,\textsuperscript{51} especially in Kenya. Nevertheless, the non-governmental organisations working with sex workers in Kenya are educating the police on appropriate ways of handling arrested sex workers.

\textit{We try to talk to them [the police] ... on appropriate ways of handling sex workers. Even if they are arrested for prostitution it is also their right to receive sexual and reproductive health and rights services even within the prison or within the remand

\begin{flushright}
\textsuperscript{38}\textsuperscript{39}
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Murder Case’ \textit{The Guardian} 14 August 2012 \texttt{<www.theguardian.com/world/2012/aug/14/kenya-prostitute-murder-british-soldiers>} accessed 7 April 2017

\textsuperscript{38} Kenya Sex Worker Alliance (KESWA) and Bar Hostess Empowerment and Support Program (BHESP), Kenya Sex Workers’ Shadow Report Submission to the United Nations Committee on the Elimination of Discrimination against Women 68th Session (KESWA and BHESP 2017) 9-10 specifies that ‘Our working environment exposes us to recurrent violence: most sex workers have been murdered in their course of work. Philip Onyancha, a serial killer who was arrested and charged with the murders of sex workers in Thika County; admitted to murdering 17 people mostly sex workers. He later claimed that he intended to kill 100 sex workers due to the fact they were approachable, had little or no security while working, no recourse if victimised, and society did not care whether they went missing or just turned up dead.’ It states further that ‘… KESWA and BHESP has recorded 20-25 murders of sex workers. Though complaints were registered in numerous police stations, no arrests were made and no investigations into the murders have been conducted. The government does little or nothing at all to make us feel safe, hence we do not enjoy fundamental rights as provided by CEDAW provisions as well as our constitution.’

\textsuperscript{39} [2007] High Court of Kenya at Nyeri Criminal Case 16 of 2005 (eKLR); [2011] Court of Appeal at Nyeri Criminal Appeal No 263 of 2007 (eKLR).


\textsuperscript{41} Alexander, ‘Prostitution: A Difficult Issue for Feminists’ (n 25) 350.
homes. So there should be [a line] between ... criminal acts and the rights to services.  

Studies have shown that the laws affecting sex workers present in almost every country in the global south are akin to laws against abortion.  

5.1.2 Contradicting Abortion Law

An estimated 22 million unsafe abortions take place each year and 98 per cent occur in the global south. Restrictive laws on termination of pregnancy exacerbate unsafe abortion. In Kenya, the Kenyan Penal Code outlaws abortion. The overly protective colonial era legislation, as Renée Pittin argues, harms the very women that it should protect. Despite these laws, scholars argue that women in much of the developing world are prepared to risk their lives when faced with an unwanted pregnancy. However, even in countries with liberal abortion laws, studies indicate that women’s understanding of the abortion law is low, and therefore accurate information on the legal context is important, and on contraception. Pittin refutes the theory that by refusing to give information on contraception, for example, this will keep women or girls away from sexual experimentation.  

This, Pittin argues, is an ‘exercise in pretence, delusion and wishful thinking.’ The irony in Kenya, however, is that post-abortion care is allowed in its public hospitals. Considering the circumstances under which unsafe abortions are conducted in the country, including stigma and...
discrimination, most women, for fear of prosecution, will go to a hospital for help when it is too late.

Abortion is permitted under certain circumstances as provided under Article 26(4) of the Constitution of Kenya, but lack of information hinders sex workers’ access to safe abortion services.\(^{62}\) Health professionals who perform abortions face a fourteen-year jail term, while women including sex workers who are found to terminate a pregnancy risk being jailed for seven years. Sections 158–160 of the Penal Code provide that:

158. Attempts to procure abortion
Any person who, with intent to procure miscarriage or a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.

159. The like by woman with child
Any woman, being with child, with intent to procure her own miscarriage, [who] unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.

160. Supplying drugs or instruments to procure abortion
Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.

It is in this criminal environment that unsafe abortions continue to escalate in Kenya and other countries with restrictive abortion laws.\(^{63}\)

5.1.3 Exploitation of Sex Workers

The Sexual Offences Act No. 3 of 2006 of the Laws of Kenya defines rape and includes both women and men as survivors and perpetrators. The Kenyan law provides minimum stringent penalties for offenders of sexual offences committed in the country, e.g. rape, defilement and gang rape. Under Section 3(1) of SOA 2006, a person commits rape if:

\[^{62}\text{Constitution of Kenya 2010, Article 26(4).}\]

(a) he or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs; (b) the other person does not consent to the penetration; or (c) the consent is obtained by force or by means of threats or intimidation of any kind. A conviction for rape attracts a minimum jail term of ten years or life imprisonment, and fifteen years for gang rape, but which may be increased to life. Section 17 of SOA Act defines ‘exploitation of prostitution’ as:

Any person –

(a) intentionally causes or incites another person to become a prostitute; and
(b) intentionally controls any of the activities of another person relating to that person’s prostitution,

and does so for or in expectation of gain for himself or herself or a third person, is guilty of an offence and is liable upon conviction to imprisonment for a term of not less than five years or to a fine of five hundred thousand shillings or to both.

It is important to note here that those involved in exploitation of sex workers have to face the law as stipulated in both national and international human rights law. In this context due regard should be given to ensure the Kenyan sex workers’ lives are not endangered further.

The SOA 2006 Act criminalises child sex tourism, child prostitution and child pornography, including prostitution with a person with mental disabilities. A child under Kenyan law is a person below the age of eighteen years. It is an offence under the Act to intentionally, knowingly and wilfully transmit HIV to another person, irrespective of whether the parties are married or not. Arguably, this provision has been used to arrest and forcefully test sex workers for HIV and other sexual transmitted infections in Kenya. The contentious Section 38 of the Sexual Offences Act was

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64 Sexual Offences Act 2006 (Kenya), Section 3(3).
65 Ibid Section 10 states that ‘Any person who commits the offence of rape or defilement under this Act in association with another or others, or any person who, with common intention, is in the company of another or others who commit the offence of rape or defilement is guilty of an offence termed gang rape and is liable upon conviction to imprisonment for a term of not less than fifteen years but which may be enhanced to imprisonment for life.’
66 Sexual Offences Act 2006 (Kenya), Section 14.
67 Ibid Section 15.
68 Ibid Section 16.
69 Ibid Section 19.
70 Children Act 2001 (Kenya), Section 2.
71 Sexual Offences Act 2006 (Kenya), Section 26.
repealed in 2012. Section 38 threatened women by imposing a similar punishment for a false allegation should their perpetrator not be jailed. Before its repeal, Section 38 of the Sexual Offences Act 2006 provided that ‘any person who makes false allegations against another person to the effect that the person has committed an offence under this Act is guilty of an offence and shall be liable to punishment equal to that for the offence complained of.’ Commentators argue that while section 38 appeared harmless on the face of it, and sought to discourage false allegations, it scared away honest complainants, the majority of whom were women, especially sex workers.

Research shows that sex workers are sexually assaulted or physically abused – they are vulnerable to sexual assault including rape and gang rape and in many cases such claims are not taken seriously even when reported to the police yet they have impact on their lives.

“My client took me to a hotel room in Nakuru, he had promised me good money. When I arrived, I saw five men in the room. I was scared, I begged to leave but he held a gun and threatened to use it if I screamed. They beat me up until I was helpless. They took turn to rape me and left me lying down and bleeding. They took my phone, money and other belongings.” Faith, 37yrs, Nakuru

Challenges are normally many because sometimes you meet a client he refuses to pay you and he beats you ... that is raping you. There was a time I met another client, he beat me until I was admitted in hospital and he refused to pay me. Even if you go to report they [police] will tell you that you are a prostitute and you know each other. You can’t be helped.

These quotations indicate the human rights violations sex workers face. In particular where sex workers face criminalisation such as in Kenya, the view of sex as work is not only problematised, but also prevents sex workers from reporting crimes against them more so to the people who should protect them even when their lives are at risk especially their right to the highest standard of physical and mental health including sexual and reproductive health.

73 Statute Law (Miscellaneous Amendments) Act 2012 (Kenya); See in KM v Republic Criminal Revision No 6 of 2014.
74 Section 38 of the Sexual Offences Act of 2006 was repealed in 2012 vide Statute Law (Miscellaneous Amendments) Act of 2012.
78 Interview with Sex Worker 3 (Nairobi, 15 July 2015).
5.1.4 Perspectives on the Criminalised Demand

This section addresses the compatibility of the Nordic Model with a human rights-based approach in the Kenyan context to inform the policy debate over there. The ‘Nordic Model’ or the Swedish law of regulating sex work in Scandinavian countries, aiming to punish the purchase of sexual services, is spreading and is a wider global issue.79 In Sweden, Norway and Iceland the purchase of sex is criminalised but not the selling.80 The Swedish Sex Purchase Act (1999) states that ‘a person who, otherwise than as previously provided in this Chapter, obtains a casual sexual relation in return for payment, shall be sentenced for purchase of sexual service to a fine or imprisonment for at most one year.’81 It states further that ‘the provision of the first paragraph shall also apply if the payment was promised or given by another person.’

According to Susanne Dodillet and Petra Östergren, Swedish law has persistently been marketed with an aim to export it to other countries,83 an assertion that is confirmed by these quotations in the work of Jay Levy and Pye Jakobsson on ‘Sweden’s Abolitionist Discourse and Law: Effects on the Dynamics of Swedish Sex Work and on the Lives of Sweden’s Sex Workers’.

I’d say that this is the one purpose of the law that the government has fulfilled ... that the law (sexköpslagen) should be exported to other countries ... irrespective of the fact that the knowledge base was so poor, I mean the empirical (knowledge) was very poor, very weak ... on the actual sex trade in Sweden. (Interview, 2010, Senior Adviser Regarding Prostitution – Socialstyrelsen)85


81 Swedish Sex Purchase Act 1999, Section 11.

82 Ibid.


85 Ibid.
I’ve had contacts with the UK government too, and I think that sooner or later they will get a Swedish legislation ... when I’m meeting people from all over the world, I’m saying ‘This is how we solved it.’ (Interview, 2010, Proposer of Sexköpslagen; Politician – Social Democrats)

Teela Sanders et al., point out that while the law on tackling demand or punishing clients remains ineffective, it is rather a ‘continued symbolic nature’ to pass the message that sex work is a crime. Studies show that decriminalising sex work, as in New Zealand, would remove the vulnerability of sex workers to exploitation and other violations and would enable sex workers to realise their sexual and reproductive health rights. Sex workers over there are subject to the same employment and legal rights as any other group. While historically, men have not been the subject of law, Andrea Krüsi and others have questioned legislative approaches that criminalise clients and argue that criminalisation-of-demand approach has devastating effects on health and human rights. They argue that such punitive laws do not reduce the violence perpetuated against sex workers, rather, they impact on the ability of sex workers to negotiate their health and safety, as well as protection from violence, which is fundamental for their enjoyment of sexual and reproductive health rights. Grenfell et al., also point out such laws do not solve the discrimination problem or address extensive harms to sex workers.

The law in Kenya, as in most African countries, criminalises activities around sex work and the debate over whether the clients of sex workers should be punished is finding its way over there. Pheterson argues that this is partly because ‘law officials are either customers themselves or they identify with customers. Prostitutes have numerous stories of the sexual demands of police, lawyers, judges and other male authorities.

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86 Ibid 604-605.
87 T Sanders, M O’Neill and J Pitcher (eds), Prostitution: Sex Work, Policy and Politics (2nd edn, Sage 2018) 120.
90 Ibid.
91 Ibid.
The participants in this study expressed their views on the Nordic Model particularly why they did not support the punishment of their clients. Feminist differ on this approach, as we have seen in chapter two, however, I argue that in a human rights-based approach the voices of sex workers in this study deserve to be heard in relation to the debates to punish their clients. In the focus group participants said:

FGD: It can’t work.
FGD: It is hard because clients are powerful people they will just bribe.
FGD: No it will spoil our work. We will lose.
FGD: But you know one thing, if he comes today and [he] is arrested and again [he is] arrested, that client will lose hope and go away completely. It is even better for him to have a mistress. It is us who will lose.
FGD: When all clients are arrested what will we eat?95

Moreover, some participants suggested that they would defend their clients against arrest ‘if a client comes I will tell him to say [to the police] that I am his girlfriend,’96 Participants in the focus group were curious to know when exactly if at all, clients would be arrested. Would it be on the streets or if found in the sexual act? In any event, they pointed out that ‘there is no way that someone can be caught in an act because by the time you are caught in the act, someone will have interfered with your privacy which is there according to the Constitution [and] many other things [rights].’97 Another view was that clients would change the venue to avert arrest ‘… If he is arrested on the [street], he will go to a club.’98

Expressing profound concern about the work environment that sex workers in Nairobi would be exposed to if their clients were criminalised, BHESP representative commented:

... I don’t think two wrongs make a right. Criminalising clients is more harmful to the sex workers. Unless the intention is to harm the female sex workers, then, they can criminalise clients. But, the intention is to create a good environment for sex workers. Sex workers have never at any time suggested that they would like their clients to be arrested on their behalf ... On the contrary, many sex workers have said, I would rather you arrest me, I can deal with it. But if you arrest the client, I lose business completely. It pushes [sex workers] further underground to more violent places, and so the criminalisation of clients, is really harmful. They [sex workers] are really going to go underground. They cannot operate on Kenyatta Avenue because a client might be arrested there, so the kind of clients they will get will be down in River Road

95 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
96 Ibid.
97 Ibid.
98 Ibid.
where maybe there are not enough policemen and where the clients are of another class and a lot of criminals.\textsuperscript{99}

For the Inspector of Police punishing clients would not make things any better. He feared that the men would not only hide but that they would be a source of infection to the society.\textsuperscript{100} Offering different thoughts the Highway Community Centre representative suggested that the level of corruption experienced in Kenya would defeat the implementation of the law focusing on clients and that a threat to expose clients to their families would probably deter.

\textit{No, the legislators are the clients of sex workers. Corruption is rife in Kenya so they cannot arrest themselves ... I mean ... what they [clients] fear most is their partner to know. So, if they [lawmakers] went in that direction it could work in Kenya. If you are found, then your partner has to know, many would stop because they value their families}.\textsuperscript{101}

Before the law to punish the clients of sex workers is at all given consideration in Kenya, the BHESP representative pointed out the importance to put into perspective the different local contexts that sex workers in Europe and Africa operate in. She highlighted that:

\textit{...Understanding the sex work in Kenya and understanding the sex work in Europe is so different. In Kenya ... in our African custom, sex work is tolerated and appreciated to the extent that men know they have a right to look after the women and so sex work is tolerated to a large extent even without the laws and everything. A man expects because you are having a sexual relationship, he pays your rent. It is a different environment. Even in some communities here in Kenya you are regarded as foolish if you are giving it [sex] for free, so to speak. In a third world country where poverty is rampant it is even seen as a way out of poverty. In some places even mothers are encouraging their daughters to get into sex work. We have seen other mothers have their children build them houses and take their siblings abroad through sex work. So it may be looked at in that sense. It is a complex environment.}\textsuperscript{102}

Amnesty International and other international organisations e.g. UN Women have called for the decriminalisation of sex work and promoting the health and human rights

\textsuperscript{99} Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
\textsuperscript{100} Interview with Inspector of Police (Nairobi, 10 July 2015).
\textsuperscript{101} Interview with Representative, Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
\textsuperscript{102} Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
of sex workers. Amnesty International points out that sex workers experience high rates of human rights abuses globally and that criminalising sex work ‘actively disempower sex workers’, and can further ‘entrench stigma, discrimination and social inequalities’, including ‘support [for] a culture of impunity for human rights abuses against them’. The decriminalisation of sex work is associated with the promotion generally of the health and human rights of sex workers. Prior to decriminalisation in New Zealand, it is argued that sex workers were exposed to exploitation, coercion and violence. However, Cheryl Overs and Bebe Loff have suggested that where the decriminalisation of sex work is not an option, ‘the way forward is grounded in addressing the variety of issues raised by sex workers and in accurately identifying the aspects of local legal environments that drive sex workers’ social exclusion and limit their access to services.’

5.1.5 Health Law in Kenya

We have a rights-based approach ... mainly in the gender programme where we are dealing with sexual and gender-based violence, a rights-based approach to reproductive health care ensuring that all women [have access] regardless. You know we also classify sex workers as vulnerable. So we ensure that they have equal access to health care [and] equal rights to sexual and reproductive health.

A human rights-based approach requires that adherence to human rights standards lead not only in the development of policy, but also in implementation as well as monitoring. In 2017, prior to submission of this PhD, Kenya passed a new law on health. At the time of the interview with the representative of the government in June 2015, the Health Bill was in Parliament and was describe to be surrounded with controversy.

104 Ibid 9.
105 Ibid.
108 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
110 Health Act 2017 (Kenya).
I heard there’s also a bit of controversy that’s why again I just say Kenyans have no heart for their own people because if you are going to change a Bill that was working so well to suit your personal needs, this is not a personal matter. This is a Bill that will be there even when we die. It’s a Bill for your kids and my grandkids. I know there was a bit of a complaint about it that it had changed from the last time it had been taken to the AG’s office so we were asked to give our input which we did and now we wait for final reading.\textsuperscript{111}

Nevertheless, given an opportunity to address sex workers face to face, the representative from the Ministry of Health said

\textit{First, I think it’s important to educate everybody on their rights like generally these are your rights, this is what is accorded to you by the Constitution. This is a right to you to access health care anywhere; it doesn’t have to be the SWOP clinic that you go to. It’s every health facility run by whoever as long as [they] are licenced by the Board [Kenya Medical Practitioners and Dentist Board] which means that [they] are licenced by the government of Kenya - you need to get certain services from there. If they can’t provide those services for one or many other reasons then they need to give you a referral to a facility that can provide you with these services. Then within the statutes of reproductive health rights the health worker can choose what contraceptive they [sex workers] need to use - the one that’s agreeable with them. They need to have information on sexually transmitted infection and HIV - how it’s presented, how to treat them and how to seek care so that you have the best care available. Thirdly, how to seek information because we give information but we rarely tell people how to seek this information where to get it from and fourth if there’s any violation for their rights, how to get redress for them.}\textsuperscript{112}

The Health Act (2017) consists of 112 Sections in seventeen parts and four schedules on how the health of individuals in Kenya will be regulated.\textsuperscript{113} This health law provides a legal framework in which to achieve the right to the highest attainable standard of health, guaranteed under Article 2(6) and Article 43 of the 2010 Constitution of Kenya, as analysed in chapter three.

\textsuperscript{111} Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
\textsuperscript{112} Ibid.
\textsuperscript{113} Part 1 (Sections 1-5) on preliminary provisions; Part II (Sections 6-21) on rights and duties; Part III (Sections 22-25) on public health facilities; Part IV (Sections 26-29) on Kenya health sector inter-governmental consultative forum; Part V (Sections 30-44) on establishment of the Kenya health human resource advisory council; Part VI (Sections 45-61) on the establishment of the Kenya health professions oversight authority; Part VII (Sections 62-67) on the regulation of health products and health technologies; Part VIII (Sections 68-72) on the promotion and advancement of public and environmental health; Part IX (Section 73) on mental health; Part X (Sections 74-79) on traditional and alternative medicines; Part XI (Sections 80-85) on human organs, human blood, blood products, other tissues and gametes; Part XII (Sections 86-87) on health financing; Part XIII (Sections 88-92) role of the private sector; Part XIV (Sections 93-102) on promotion and conduct of research for health; Part XV (Sections 103-105) on e-health; Part XVI (Sections 106-108) on inter-departmental collaboration; and Part XVII (Sections 109-112) on transitional and miscellaneous provisions.
The Health Act (2017) states that it is:

An Act of Parliament to establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care services and health care service providers, health products and health technologies and for connected purposes.\(^{114}\)

The new health law in Kenya out rightly utters the three primary responsibilities under international human rights law: to respect, protect and fulfil.\(^{115}\) The law states that ‘it is a fundamental duty of the State [Kenyan government] to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health including reproductive health care and emergency medical treatment’.\(^{116}\) Rights imply duties and duties demand accountability.\(^{117}\) The most important source of added value in the human rights approach Andrea Cornwall and Celestine Nyamu-Musembi argue, is the emphasis it places on the accountability of policy-makers and other actors whose actions have an impact on the rights of people\(^{118}\) more so, women and sex workers in particular.

The Health Act (2017) sets out five objects to.\(^{119}\)

(a) establish a national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services;

(b) protect, respect, promote and fulfil the health rights of all persons in Kenya to the progressive realisation of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment;

(c) protect, respect, promote and fulfil the rights of children to basic nutrition and health care services contemplated in Articles 43(1)(c) and 53(1)(c) of the Constitution;

(d) protect, respect, promote and fulfil the rights of vulnerable groups as defined in Article 21 of the Constitution in all matters regarding health; and

\(^{114}\) Health Act 2017. The Act was assented on 21 June 2017 and commenced on 7 July 2017.


\(^{116}\) Health Act 2017, Section 4.


\(^{118}\) Ibid.

\(^{119}\) Health Act 2017, Section 3.
recognise the role of health regulatory bodies establishes under any written law and to distinguish their regulatory role from the policy making function of the national government.

Section 5(1) expressly guarantees the right to the highest attainable standard of health for every individual,\(^{120}\) including sex workers, in Kenya, and it obligates the Kenyan government to ensure that the constitutional right to health, including reproductive health care and emergency medical treatment, is observed, respected, promoted and fulfilled. Section 5(2) provides for dignified healthcare services, echoing Article 28 and others of the 2010 Kenyan Constitution.\(^ {121}\) Kenyan health law guarantees women free maternity care\(^ {122}\) and further requires the government to develop laws, policies and similarly to put in place other measures as necessary to ensure the well-being of every Kenyan, including sex workers.\(^ {123}\) In *M A & Another v Honourable Attorney General & 4 others*,\(^ {124}\) the court in Kenya held that the detention of women in hospital for non-payment of maternity fees violated the Constitution and human rights standards guaranteed under international treaties.\(^ {125}\) In her remarks, the then Deputy Chief Justice of the Supreme Court of Kenya said:

> As judicial officers, it is our duty to ensure that the state meets its obligations to observe, protect, promote and to fulfil socio-economic and cultural rights by ensuring that the government refrains from interfering with the enjoyment of these rights; prevents others from interfering with the enjoyment of these rights and adopts appropriate positive measures towards realisation of these rights.\(^ {126}\)

The Kenyan government has an obligation to eliminate gender discrimination and enhance women’s equality in accessing sexual and reproductive health goods, services

\(^{120}\) Ibid Section 5(1).
\(^{121}\) Health Act 2017 (Kenya), Section 5(2); See *Isaac Ngugi v Nairobi Hospital & 3 Others* Petition No 407 of 2012 [34]. In this case, Majanja J held that a person’s detention for non-payment of a medical bill violated their constitutional right to dignity and liberty guaranteed under the Constitution of Kenya 2010, specifically in Articles 28 and 29.
\(^{122}\) Health Act 2017, Section 5(3)(b).
\(^{123}\) Ibid Section 6(a).
\(^{124}\) [2016] High Court at Nairobi Petition No. 562 of 2012 (eKLR).
\(^{125}\) Ibid.
\(^{126}\) K Rawal, ‘The Closing remarks by the Deputy Chief Justice Hon Kalpana Rawal, SC, Deputy President of the Supreme Court of Kenya at the Seminar on Socio-Economic and Cultural Rights Jurisprudence for the Judicial Officers in East Africa’ (Judiciary Training Institute Nairobi on 21 November 2013).
and facilities for their enjoyment of sexual and reproductive health rights. Discussing the function of the government, the policy maker said ‘health is a government function … we don’t leave it to private practitioners or to NGOs. You may get funding as NGOs but the function of ensuring that equitable health, rights and access is our docket.’

The first Kenyan health law under the new constitutional order mentions ‘women’ six times, ‘right’ 34 times and ‘duty’ seven times. It defines 37 terms, including health, abortion and informed consent. Health is defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,’ abortion as the ‘termination of a pregnancy before the foetus is viable as an independent life outside the womb’ and informed consent as ‘a process of getting permission before conducting a health care prevention on a person.’

Section 11 guarantees women a right to privacy and confidentiality in relation to information relating to their sexual and reproductive health. Studies have shown that where women’s privacy and confidentiality are respected, they tend to use the health services provided in a facility more. If women’s privacy and confidentiality are breached the situation is different; for example, a study in Kenya found that women preferred to deliver at home or alternatively with the help of traditional birth attendants (TBAs) for fear of being tested for HIV in health facilities.

In addition, Section 6 of the new health law guarantees every person in Kenya, who include sex workers, the right to sexual and reproductive health. Reproductive health was described during my fieldwork as a big grey area that policy has to address.

... I think reproductive health is grey area number one for Kenyans because it encompasses so many things that are just taboo in this society. Eventually and I am a

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128 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
129 Health Act 2017, Section 2.
130 Ibid.
131 Ibid.
132 Ibid.
133 Ibid Section 11.
big believer in eventually just by getting these things into the system will have an impact in the long run. The problem with health is that you rarely get instant results and so I am sure even with things like justice you may have the systems in place but it takes some time to see the results.\textsuperscript{136}

Section 6 specifies that:

(1) Every person has a right to reproductive health care which includes –

(a) the right of men and women of reproductive age to be informed about, and to have access to reproductive health care services including safe, effective, affordable and acceptable family planning services;

(b) the right of access to appropriate health-care services that will enable parents to go safely through pregnancy, childbirth, and the post-partum period, and provide parents with the best chance of having a healthy infant;

(c) access to treatment by a trained health professional for conditions occurring during pregnancy including abnormal pregnancy conditions, such as ectopic, abnormal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened. All such cases shall be regarded as comprising notifiable conditions.\textsuperscript{137}

And defines ‘a trained health professional’ in Section 6(2) as:

… a health professional with formal medical training at the proficiency level of a medical officer, a nurse, a midwife, or a clinical officer who has been educated and trained to proficiency in the skills needed to manage pregnancy-related complications in women, and who has a valid licence from the recognised regulatory authorities to carry out that procedure.\textsuperscript{138}

According to Kenyan health law, procedures carried out under Sections 6(1)(a) and 6(1)(c) shall be performed in ‘a legally recognised health facility with an enabling environment consisting of the minimum human resources, infrastructure, commodities and supplies for the facility as defined in the norms and standards developed under this Act.’\textsuperscript{139} It guarantees sex workers the right to emergency treatment\textsuperscript{140} and defines

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{136} Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
\item \textsuperscript{137} Health Act 2017, Section 6; See also AAA v Registered Trustees (Aga Khan University Hospital, Nairobi) [2015] eKLR, Civil Case No. 3 of 2013 (High Court of Kenya at Nairobi), paras 1 and 19. In this case, the plaintiff sued for unwanted pregnancy due to medical negligence. She had two children and did not want to have more. She sought medical advice on the most appropriate contraceptive for her from the family planning clinic in Aga Khan Hospital. She followed the professional medical advice but unexpectedly became pregnant. The court held that medical practitioners and the health facilities that provide family planning services owe their patients a duty of care to provide family planning services that are to the professional standards expected of them. The plaintiff was awarded damages.
\item \textsuperscript{138} Health Act 2017 (Kenya), Section 6(2).
\item \textsuperscript{139} Ibid Section 6(3).
\item \textsuperscript{140} Ibid Section 7(1).
\end{itemize}
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‘emergency treatment’ as ‘necessary immediate health care that must be administered to prevent death or worsening of a medical situation.’

Meanwhile, Section 12 permits healthcare providers to ‘refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her except in an emergency situation where no alternative health care personnel is available.’ The Act fails to define ‘physically abusive’ or ‘verbally abusive’ users yet, this provision maybe open to misinterpretation especially in a health sector where sex workers face stigmatised and discriminatory treatment when they access their sexual and reproductive health services. In the list of issues submitted to the CEDAW 68th Pre-Sessional Working Group, sex workers expressed their concern that they ‘routinely face discrimination and stigma by health care professionals in both government and private hospitals. Their access to comprehensive health services, including sexual and reproductive health services are often obstructed and denied.’ While sex workers have their constitutionally guaranteed right to health, they equally have the ‘right to health information and information for health’. Explaining what this means for health practitioners, the FHOK representative stated ‘health information’ related to sex workers ‘right to access their medical records and see the profile of their health … including to ask to be explained to, to understand what it means, so as to know her sexual and reproductive health’. She mindfully added

*That law that is covering me, that international law that is covering me to access my profile ... from the time I was even born, she [sex worker] has also got the same rights. That would make sex workers access quality health. With the trend of your health, you will be able to see what is going on. But now for her, because of what she is, she may not access this. She may go ... someone will check and say ‘ah! This one is a sex worker’. That already has blocked her quality health.*

Information relating to health, however, are ‘brochures, IEC [information, education and communication] materials, some documentaries and so forth.’ Therefore, the focus must be that sex workers participate in the development of information relating to sexual and reproductive health.

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141 Ibid Section 2.
142 Ibid Section 12(c).
144 Interview with Representative 2 of Family Health Options Kenya (Nairobi, 23 June 2015).
145 Ibid
146 Ibid.
The Cabinet Secretary responsible for health in Kenya has a legal mandate to make different regulations for implementation of the provisions of the Health Act 2017 and further to, ‘implement within Kenya measures agreed upon within the framework of any treaty, international convention or regional intergovernmental agreement to which Kenya is a party.’

The Act stipulates 26 duties of the national government, including to ‘ensure the implementation of rights to health specified in the Bill of Rights and more particularly the progressive realisation of the right of all to the highest attainable standard of health including reproductive health care and the right to emergency treatment.’

Section 30 establishes the Kenya Health Human Resource Advisory Council and Section 45, the Kenya Health Professions Oversight Authority whose functions include:

(a) maintain a duplicate register of all health professionals working within the national and county health system;
(b) promote and regulate inter-professional liaison between statutory regulatory bodies;
(c) coordinate joint inspections with all regulatory bodies;
(d) receive and facilitate the resolution of complaints from patients, aggrieved parties and regulatory bodies;
(e) monitor the execution of respective mandates and functions of regulatory bodies recognised under an Act of Parliament;
(f) arbitrate disputes between statutory regulatory bodies, including conflict or dispute resolution amongst Boards and Councils; and
(g) ensure the necessary standards for health professionals are not compromised by the regulatory bodies.

In Kenya, several attempts have been made to introduce a law to address sexual and reproductive health issues, but this has often been met with strong opposition, particularly for its inclusion of abortion clauses. For example, the Reproductive Health Care Bill 2014 states in Clause 19 that:

(1) A pregnancy may be terminated if a trained health professional, after consultation with the pregnant woman, is of the opinion that –
(a) the continued pregnancy would endanger the health of the mother; or
(b) as a result of the pregnancy the life or health of the mother is in danger.

147 Health Act 2017 (Kenya), Section 15(2)(a) and (b).
148 Ibid Section 15(1)(c).
149 Ibid Section 30.
150 Ibid Section 48.
(2) Trained health professionals shall offer non-mandatory and non-directive counselling, before and after the termination of pregnancy.

Clause 20 provides that the termination of pregnancy may take place –

(a) only with the consent of the pregnant woman;
(b) in the case of a pregnant minor, after consultation with the minor’s parents, guardian or such other persons with parental responsibility over the said minor, provided that the best interest of the minor shall prevail; or
(c) in the case of a mentally unstable person, after consultation with the parents, guardian or such other persons with parental responsibility over the said person.

Treaty monitoring bodies have regularly recommended to the Kenyan government to pass the Reproductive Health Rights Bill into law.\textsuperscript{152} In my telephone interview with a policymaker and representative of the Division of Reproductive Health in the Kenya Ministry of Health she commented that

... [in] my personal opinion, I am for the [Reproductive Health Bill]. I think it needs to align to the bigger Health Bill. It needs to align to the policies that are currently in the Ministry [of Health]... I know it will get a big fight in Parliament ... The Reproductive Health Bill was well drafted, it has come at a good time, a time of need. It needs to be housed in the Health Bill so that it can get more traction... it addresses a lot of grey areas in the Constitution in fact that’s the part I really want to see how it will go down because I know how Parliament works. Depending on someone’s interest they will sway it. There are a few technical and structural adjustments to be made, which I know a team from Afya House has been working on. So I look forward to see how it will turn out.\textsuperscript{153}

I sought to find out what these grey areas in the Reproductive Health Rights Bill are and the policy maker noted ‘I mean abortion right’\textsuperscript{154} and explained

They are giving full abortion right to abortion on demand. Our Constitution very strongly stood up against that so I want to see ... I hear the argument that has been brought forward by the drafter but I want to see how it plays out in Parliament because it’s very political and all these things are political so let’s see how it works out.\textsuperscript{155}

\textsuperscript{152} Committee on the Elimination of Discrimination against Women, Concluding observations Kenya UN Doc CEDAW/C/KEN/CO/7, para 37.
\textsuperscript{153} Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
\textsuperscript{154} Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
\textsuperscript{155} Ibid.
Drawing from the experience of the Prohibition of Female Genital Mutilation Bill that generated a lot of heated debate for years before it was eventually passed into law but which has not stopped the FGM practice either, the policy maker said:

And you would think FGM is a straightforward thing ... it turns out it’s not. People are passionate about ensuring women are mutilated ... those are the things I still keep saying on a personal note I can’t understand. In fact FGM it really gets to me because it plays no role in anything ... I have sat in meetings, we have tried to advocate against it (sighs) I don’t know it leaves me feeling demotivated with my work. Something as simple as this is getting people up in arms as in literally fist fights yeah? What are we doing to our women? Has anybody thought about that woman, that young girl who is 13 trying to labour? ... When you get me started on FGM I can almost go for a day but those are the concerns I have. At the end of the day where do we feature the people who are actually affected by denying [them] these rights?

5.2 The Policy Environment Affecting Sexual and Reproductive Health Rights

This section reviews three key policies and reveals the extent to which they govern the sexual and reproductive health rights of women, including sex workers, in Kenya, but also how they assert the rights-based application of sexual and reproductive health services. They are: the Kenya Health Policy 2012–2030, the National Reproductive Health Policy (2007) and the recently reviewed National Adolescent Sexual and Reproductive Health Policy (2015).

5.2.1 Kenyan Health Policy 2012–2030

Before the coming into force of the Health Act (2017), health in Kenya was governed by the Kenya Health Policy (2012–2030). In 2012, the government of Kenya adopted a new health policy to implement health and related provisions in the Constitution and in tandem with Vision 2030, the national long-term blueprint. The Policy states that ‘the Constitution of Kenya (2010) provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery.’

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156 Prohibition of Female Genital Mutilation Act No 32 of 2011.
157 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
159 Kenya Health Policy 2012-2030 (Kenya).
The Constitution of Kenya (2010) introduced a devolved system of government consisting of one national government and forty-seven county governments, e.g. Nairobi County, Kisumu County and Mombasa County. The objectives of devolution are to: (i) promote democracy and accountability in the delivery of healthcare, (ii) foster seamless service delivery during and after a transition period, (iii) devolve powers of self-governance to the people and enhance their participation in making decisions on matters of health affecting them, (iv) recognise the right of communities to manage their own health affairs and further their development, (v) protect and promote the health interests and rights of minorities and marginalised communities, including informal settlements such as slum-dwellers and under-served populations, (vi) promote social and economic development and the provision of proximate, easily accessible health services throughout Kenya, (vii) ensure equitable sharing of national and local resources targeting health delivery throughout Kenya, (viii) enhance the capacities of the two levels of governments to effectively deliver health services in accordance with their respective mandates, (x) facilitate the decentralisation of state organs responsible for health, their functions and services from the Capital of Kenya, and (x) enhance checks and balances and the separation of powers between the two levels of government in the delivery of healthcare. At the national level, the representative from the Ministry of Health said ‘mainly now as the national government we are not implementers, we are more of policy makers. We build capacity, we supervise, we monitor and evaluate our programmes and we coordinate partners who work in the field as well.’

The key objectives of Kenya Health Policy (2014–2030) are: eliminate communicable conditions, halt and reverse the rising burden of non-communicable conditions, reduce the burden of violence and injuries, provide essential healthcare, minimise exposure to health risk factors, and strengthen collaboration with private and other health-related sectors. The main goal of Kenya Health Policy (2014–2030) is ‘to attain the highest possible standard of health in a responsive manner.’ To attain the policy goal, it will

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160 Ibid.
161 Ibid 3.
162 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
164 Ibid 29.
‘support equitable, affordable, and high-quality health and related services at the highest attainable standard for all Kenyans.’

The health policy lays out these three principles that guide its implementation: (i) public participation, in which a people-centred approach and social accountability in planning and implementation shall be encouraged, in addition to a multi-sectoral approach to overall development planning, (ii) efficiency in the application of health technologies, and (iii) mutual consultation and cooperation between the national and county governments and among county governments.

The Kenya Health Policy (2012–2030) promises to deliver an obligation for:

- Progressive realisation of the right to health: The national and county governments will put in place measures to progressively realise the right to health as outlined in Article 21 of the Constitution. The sector will employ a human rights-based approach in healthcare delivery and will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programmes. This includes human dignity; attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalised groups, and older members of the society (Constitution of Kenya 2010 Articles 53–57); and ensuring that health services are made accessible to all.

- Healthcare service delivery systems will be reoriented towards the application of principles and practices of social accountability, including reporting on performance, the raising of public awareness, fostering transparency, and public participation in decision-making on health-related matters.

There will be no exclusion or social disparities in the provision of healthcare services. Services shall be provided equitably to all individuals in a community, irrespective of their gender, age, caste, colour, geographical location, tribe/ethnicity, and socioeconomic status. The focus shall be on inclusiveness, non-discrimination, social accountability, and gender equality.

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165 Ibid.
166 Ibid 5.
167 Ibid 30.
168 Ibid 28.
169 Ibid.
5.2.2 National Reproductive Health Policy (2007)

Guided by several principles,\(^{170}\) the Kenya National Reproductive Health Policy (2007) set out to ‘improve [the] reproductive health state of all people in Kenya by increasing equitable access and improving [the] quality, efficiency and effectiveness of service

\(^{170}\) Government of Kenya, National Reproductive Health Policy 2007 (Ministry of Health 2007) 9 illustrates the following principles as what guided its development of the Policy, hence to guide its implementation:

(a) Human rights and freedoms must be respected by all, regardless of religion, culture and socio-economic status. Reproductive and sexual health rights, within the context of the law, are components of human rights, should be observed and adhered to by service providers who should recognise that:

(i) all couples and individuals have the basic right to decide freely and responsibly the timing, number and spacing of their children, have access to information and education in order to ensure optimal health and informed decision-making.

(ii) all people have the right to decide freely and responsibly on all aspects of their sexuality, and have the right to be free from conditions that interfere with sexual health such as harmful practices; sexually acquired conditions including sexually transmitted infections (STIs) and HIV/AIDS; complications associated with menopause and andropause; and coercion into having sex and other forms of sexual violence.

(b) Reproductive health care must be responsive to expressed needs of the consumers. Individuals and/or communities, have both rights and responsibilities in promoting their own health and development. Mechanisms to achieve consumer participation in decision-making, planning, implementation, monitoring and evaluation (M&E) of reproductive health programmes (Health Committees, Health Boards, etc.) must be available to consumers.

(c) Failure to prevent maternal and newborn deaths is a social injustice that violates human rights. In this respect, RH providers must endeavour to eliminate factors that impede equitable access to RH services and in particular the reduction of financial, social, political and cultural barriers to those seeking reproductive health information and services, especially among the more vulnerable members of the population.

These include, but are not limited to:

(i) People with disabilities;

(ii) People infected or affected by HIV/AIDS;

(iii) Orphans and vulnerable children (OVC), homeless, refugees and abused persons;

(iv) Youth and adolescents, including single parents;

(v) The poor in urban, rural and hard to reach areas;

(vi) Elderly persons; and

(vii) Infertile couples.

(d) Reproductive health and HIV/AIDS services have certain advantages if planned and provided in an integrated way to mutual advantage.

(e) Provision of reproductive health services are enhanced by policies and programmes that promote gender equity and equality, empower women and eliminate all forms of gender-based violence and related harmful practices. Gender equity and equality must be addressed at all levels of services deliver, including information and M&E. Involvement of men as RH consumers and responsible partners to women will increase access to and use of RH services, including STI prevention and treatment services by both women and men.

(f) There are many providers of reproductive health services besides the Ministry of Health (MoH) and its agencies. These include other government ministries, NGOs, FBOs, for-profit private sector organisations, CSOs and communities, all of which have expanded access to RH information and services.

(g) The Ministry of Health through the Division of Reproductive Health (DRH) has stewardship of the national reproductive health programme. Consequently, all RH providers are required to operate according to the national RH Strategic Plan and all norms and standards set by the MoH, within the spirit of these principles.

(h) Implementation of this policy should be guided by adoption of evidence-based practices, a human rights approach, quality improvement, standard setting and audit, and application of appropriate and cost-effective technologies.
delivery at all levels.\textsuperscript{171} Its policy objectives include: reduce maternal, perinatal and neonatal morbidity and mortality; reduce unmet family planning needs; improve the sexual and reproductive health of adolescents and youth; promote gender equity and equality in matters of reproductive health, including access to appropriate services; contribute to reduction of the HIV/AIDS burden and improvement in the reproductive health status of infected and affected persons; reduce the burden of reproductive tract infections (RTIs) and improve access to, and the quality of, RTI services; reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile individuals and couples; reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women; address reproductive health-related needs of the elderly; and address the special reproductive health-related needs of people with disabilities.\textsuperscript{172}

5.2.3 Adolescents’ Sexual and Reproductive Health Rights Policy (2015)

It is estimated that about 24 per cent of Kenya’s population comprises adolescents,\textsuperscript{173} and the National Adolescent Sexual and Reproductive Health Policy (2015) aims to ‘enhance the SRH status of adolescents in Kenya and contribute towards realisation of their full potential in national development.’\textsuperscript{174} Respect for human rights and fundamental freedoms are among its implementation principles.\textsuperscript{175} This includes, according to the Adolescent SRH Policy: the right to life, human dignity, equality and freedom from discrimination on the basis of gender, sex, age, disability, health status, geographical location or social, cultural and religious beliefs and practices.\textsuperscript{176}

In line with the World Health Organisation, the National Adolescent Sexual and Reproductive Health Policy (2015) defines adolescents as ‘persons aged between 10 and 19’\textsuperscript{177} and health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.’\textsuperscript{178} It also defines reproductive health, sexual health, and sexual and reproductive health rights. Reproductive health is ‘a state

\textsuperscript{171} Ibid 1.
\textsuperscript{172} Ibid 9.
\textsuperscript{173} National Adolescent Sexual and Reproductive Health Policy 2015 (Kenya), 5 and 9.
\textsuperscript{174} Ibid 6.
\textsuperscript{175} Ibid 8.
\textsuperscript{176} Ibid.
\textsuperscript{177} Ibid ix.
\textsuperscript{178} Ibid 1.
of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.\textsuperscript{179} and sexual health is:

\ldots a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.\textsuperscript{180}

Adolescent SRH Policy further defines sexual and reproductive health rights as ‘the exercise of control over one’s sexual and reproductive health linked to human rights’ and includes the right to: Reproductive health as a component of overall health, throughout the life cycle, for both men and women; reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of one’s children, a right to access information and the means needed to exercise voluntary choice; equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

Adolescent SRH Policy undertakes to provide adolescent-friendly services and sets out key quality components for health services in Kenya to be considered adolescent-friendly. They have to be effective, efficient, accessible, acceptable and patient-centred; there have to be equitable, safe, available age-appropriate comprehensive SRH services; private and confidential, adolescent-friendly healthcare providers; adolescents and community have to be involved, and reliable and consistent.\textsuperscript{181}

\subsection*{5.3 Sexual and Reproductive Health Rights-Related Challenges}

Health systems are only as effective as the services they provide.\textsuperscript{182} In a country with a population of approximately 46 million, there are 512 level 4-6 hospitals, 1.3 hospitals per 100,000 of population, 8,104 health centres and dispensaries and 19.9 health centres

\textsuperscript{179} Ibid 2.
\textsuperscript{180} Ibid.
\textsuperscript{181} Ibid 24.
\textsuperscript{182} World Health Organisation (WHO), ‘Key Components of a Well Functioning Health System’ (World Health Organisation 2010).
and dispensaries per 100,000.\textsuperscript{183} The Shadow Report to the Committee on Economic, Social and Cultural Rights from the Kenyan National Commission on Human Rights indicates that, generally, access to health is still a big hurdle for the majority of Kenyans, especially women, particularly when about ‘a quarter of Kenyan households are located more than 8 kilometres from any form of health facility.’\textsuperscript{184} According to WHO, a well-functioning health system is one that responds in a balanced way to a population’s needs and expectations by:

 impro\underline{\textit{ving the health status of individuals, families and communities; defending the population against what threatens its health; protecting people against the financial consequences of ill-health; providing equitable access to people-centred care; making it possible for people to participate in decisions affecting their health and health system.}}\textsuperscript{185}

The Kenyan government, through its health sector, has a human-rights obligation to implement the new health law and ensure sexual and reproductive health goods,

\textsuperscript{183} Kenya Health Policy 2012-2030, 15-16; See Health Act 2017, First Schedule classify healthcare delivery as Level 4: Primary Hospital whose functions are:  
(a) Clinical supportive supervision to lower level facilities  
(b) Referral level out-patient care  
(c) In-patient services;  
(d) Emergency obstetric care and oral health services;  
(e) Surgery on in-patient basis;  
(f) Client health education;  
(g) Provision of specialized laboratory tests;  
(h) Radiology services;  
(i) Proper case management of referral cases through the provision of four main clinical specialities (i.e. internal medicine, general surgery, gynaecobstetrics and paediatrics) by general practitioners backed by appropriate technical devices;  
(j) Proper counter referral;  
(k) Provision of logistical support to the lower facilities in the catchment area;  
(l) Coordination of information flow from facilities in the catchment area.  

Level 5: Secondary Hospital whose functions are:  
(a) Provision of specialised services;  
(b) Training facilities for cadres of health workers who function at the primary care level (paramedical staff);  
(c) Serves as an internship centre for all staff, up to medical officers;  
(d) Serves as a research centre, that provides research services for issues of county importance;  

Level 6: Tertiary Hospital:  
(a) Provides highly specialised services. These include –  
(i) general specialisation;  
(ii) discipline specialisation; and  
(iii) geographical/regional specialisation including highly specialised healthcare for area/regional specialisation;  
(b) Research centre, provides training and research services for issues of national importance.

\textsuperscript{185} WHO, ‘Key Components of a Well Functioning Health System’ (n 165).
services and facilities are available, accessible, acceptable and of good quality to women, especially sex workers.

In spite of this, Joseph Kirigia and others raise concerns about the brain drain of health professionals especially doctors and nurses, the ‘backbone’ of the health system, from developing countries including Kenya to developed countries, e.g. the UK, the USA and Canada. Health professionals are central to achieving sexual and reproductive health rights; for example, studies in Africa reveal that nurse-led antiretroviral therapy (ART) services are linked to a considerably higher retention of patients in HIV care and treatment, and this significantly improves the quality of care for people living with HIV, the majority of whom are women, especially sex workers. However, they are ‘pulled’ to developed countries due to several factors, e.g. low salaries, poor health facilities and lack of health research funding, which the Kenyan government must address.

FIDA Kenya’s Joint Shadow Report to the Committee on Economic, Social and Cultural Rights notes that the majority of women in Kenya are not aware of their rights, including the means to enforce them, and that the government’s lack of political will to enact laws and implement them fully risks taking women back into the pre-2010 Constitution era. Kenyan laws are confusing and contradictory and many a time, according to the Centre for Reproductive Rights, contribute to the barriers that women, including sex workers face in accessing sexual and reproductive health rights, e.g. abortion and timely post-abortion care, family-planning information and services. While NGOs in Kenya and other East African countries have submitted shadow reports to CEDAW, the Shadow report by the Kenyan sex workers is unique and their ‘Talking

190 See Centre for Reproductive Rights, Letter to the Committee on Economic, Social and Cultural Rights: Supplementary Information on Kenya, Scheduled for Review by the Committee on Economic, Social, and Cultural Rights during its 57th Session (Centre for Reproductive Rights 1 February 2016).
should never be used to avoid acting,’\textsuperscript{191} on the part of the Kenyan government. For the first time as pointed out in section 3.2, women who do sex work in an East African country assert their convention rights and tell their personal experiences directly to the 68\textsuperscript{th} CEDAW Committee so as to be heard. Sex workers reveal in the Report the humiliation and intimidation they face in the hands of those who are supposed to ensure they receive quality treatment and protection against violation of their constitutional guaranteed rights to sexual and reproductive health. In the health facilities, healthcare providers insult sex workers and in the police custody, they are denied anti-retroviral therapy risking their lives as illustrated in the excerpts below:

\begin{quote}
I was received with abusive words. ‘This is a sex worker who has been out there snatching other women’s husbands. Now she has been stabbed. Just stitch her, if it heals let it heal well and good, if not so be it.’ BSA 002 – Bar hostess in Busia County who works alone with clients contacting her directly.\textsuperscript{192}

In the 2 years I was working as a sex worker, like 4 times I was taken to a police cell like for periods of up to a week. I was positive and I knew it. I can say the number of time I was in prison I did not access my ARVs, which resulted in the deterioration of my health, which really affected my life. (Purity Nairobi County)\textsuperscript{193}

It was a bad experience because I stayed without medication leading to deterioration of my health. My CD4 went down and I also lost weight. When I went back for treatment, the doctors were harsh to me for defaulting and told me in such cases I should speak out and ask for help. They had also tried looking for me but they did not know I was arrested. This situation is not likely to change because the police officers are always harsh and not ready to listen.\textsuperscript{194}
\end{quote}

The experiences of these women shade the light on the hurdles that sex workers grapple with because of who they are which unfortunately prevent them from enjoying their sexual and reproductive health rights. On the other hand, it echoes the importance of the police and healthcare providers to work with the sex workers and not to take advantage of their vulnerable circumstances instead use the law to protect the right to enjoyment of sexual and reproductive health as promised in the 2010 Kenyan Constitution, international human rights treaties and other laws. By doing this, I argue, would there be

\textsuperscript{191} M Robinson, ‘Foreword’ in D Buss and A Manji (eds), \textit{International Law: Modern Feminist Approaches} (Hart 2005)

\textsuperscript{192} Kenya Sex Worker Alliance (KESWA) and Bar Hostess Empowerment and Support Program (BHESP), Kenya Sex Workers’ Shadow Report Submission to the United Nations Committee on the Elimination of Discrimination against Women 68th Session (KESWA and BHESP 2017) 10.

\textsuperscript{193} Ibid 11.

\textsuperscript{194} Ibid.
a lasting and meaningful change in the sexual and reproductive health lives of sex workers.

5.4 Conclusion

This chapter has exposed current legislative and policy with respect to sexual and reproductive health rights and that Kenya is making legislative and policy efforts to implement Article 43 of the Constitution, promulgated on 27 August 2010, including the right to the highest attainable standards of health, including reproductive healthcare as well as several related rights as affirmed in human-rights treaties. The chapter has argued that there are a myriad of challenges that remain barriers to the enjoyment of sexual and reproductive health rights by many women, including sex workers, such as lack of information on family planning and confusing and contradictory laws, as well as quality healthcare services, goods and facilities.

In particular, the chapter has revealed the burden that criminal law imposes on sex workers who, in most cases, are arrested, harassed and even forced to take HIV tests and risk prosecution. The chapter further reveals the failure on the part of the government of Kenya to protect the fundamental right to life and other sexual and reproductive health-related rights guaranteed in the Constitution and in the Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Economic, Social and Cultural Rights and the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa.

The Health Law Act (2017) has just come into force and needs a multi-sectoral approach and adequate financing of the health sector to ensure that women who are sex workers enjoy their sexual and reproductive health rights according to international human rights standards and principles of participation and inclusion, accountability and transparency, non-discrimination and equality, empowerment and, finally, the rule of law.

On the Nordic Model, the chapter acknowledges that sex-work law is a hot debate in many parts of the world. More so, it has shown that the debate over criminalising the clients of sex workers is spreading around the globe and that such a debate, particularly in Kenya, must put the voices of sex workers at the centre and be cautious about their
sexual and reproductive health rights. Although the criminal law in Kenya seems to target both male and female sex workers, the analysis in this chapter confirms that female sex workers bear the brunt of the law\textsuperscript{195} and that the government should decriminalise sex work. In the next chapter I present the original empirical research from my fieldwork.

\textsuperscript{195} Ngwena, ‘Sexual Health and Human Rights in the African Region’ (n 18) 235.
Chapter Six

Findings

The Constitution of Kenya 2010 has opened up space and it gives us [sex workers] an opportunity to address the clauses that make sex work illegal.¹

6.0 Introduction

This chapter constitutes an original piece of empirical research, based on fieldwork in Kenya focusing on sex workers, NGOs, government officials, health professionals and police which adds exceptional value, for it contributes at this juncture to investigating the relatively young human rights culture in Kenya and how marginalised groups are treated in such a new and challenging environment.² In particular, the in-depth interviews and the focus-group discussion in this chapter help in determining the focus of the Kenyan government vis-à-vis women’s struggle to enjoy their sexual and reproductive health rights. The findings in this chapter illuminate the extent to which sexual and reproductive health rights are respected, protected and fulfilled. They reveal the reality of the international, regional and national laws and policies critically analysed in chapters three and five and the real experiences of sex workers in their daily lives. Importantly, these experiences as stated in sections 6.2.1 and 6.2.2 answer the research questions: ‘What are sexual and reproductive health rights?’ and ‘In what ways can sex workers realise their sexual and reproductive health rights?’

Two main themes and subthemes are identified and discussed in this chapter. First, section 6.1 presents detailed demographic information on sex workers, starting with numbers, age and education (in section 6.1.1). The sex workers’ reasons for starting sex work, including sex workers’ marital status, are presented (in section 6.1.2) along with sex worker hotspots (in section 6.1.3).

¹ Interview with the Representative of Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
Two main thematic areas are discussed (in section 6.2) to argue that sexual and reproductive health rights should be enjoyed by sex workers too. Section 6.2.1 presents factors that promote the enjoyment of sexual and reproductive health rights by sex workers in Kenya, supported by four subthemes: knowledge of sexual and reproductive health rights (in section 6.2.1.1), the Constitution and the ‘Opened-Up’ space (in section 6.2.1.2), nothing for us without us (in section 6.2.1.3) and capacity-building (in section 6.2.1.4).

Section 6.2.2 discusses the factors that hinder the enjoyment of sexual and reproductive health rights, supported by six subthemes. They are: the underfunded Health Sector (in section 6.2.2.1), ambiguous and confusing policies (in section 6.2.2.2), the criminal law and sex workers (in section 6.2.2.3), bribery and police harassment (in section 6.2.2.4), violence against sex workers (in section 6.2.2.5) and stigma and discrimination (in section 6.2.2.6). Finally, the chapter draws a conclusion that sexual and reproductive health rights are fundamental to sex workers (in section 6.3).

6.1 Demographic Information

6.1.1 Approximate Numbers, Age, and Education

Studies estimate that there are approximately 200,000 sex workers in Kenya, 185,000 of whom are women; and of those, 50,000 are Nairobi residents. Mastin and others point out that ‘while these numbers are compelling, women employed in sex work are often seen as nothing more than these depersonalised statistics and face stigmatised inequality and discrimination by both a general public and at times even their health care providers.’ These attitudes against sex workers perpetuate their subordination and HRBAs empowers them.

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4 Mastin et al., ‘Having Their Say: Sex Workers Discuss Their Needs and Resources’ (n 3).
5 KJ Maschke (ed), Feminist Legal Theories (Garland Publishing Inc 1997) 127.
In Nairobi, we have about 7,000 sex workers that report daily in the CBD [Central Business District], that is, at night ... These are only female sex workers who have come out and said I am a sex worker and I belong in [the] sex work family.\(^6\)

When we talk about numbers [of female sex workers in Kenya] I always put a figure of 200,000 plus ... Nairobi has the highest and so Mombasa and other [towns] take care of the 120,000 ... In Nairobi I can put the number as close to 80,000 to 100,000 only women.\(^7\)

The 16 sex workers who participated in this study were over 18 years of age. The youngest sex worker was 22 and the oldest 40. When asked for how long they had done sex work, their responses varied from under two years to the longest who started sex work immediately after she gave birth to her first-born child, who was at the time of the interview 22 years old.\(^8\) Some of the participants had started sex work when they were children, despite the Kenyan sexual offences law of 2006 which outlaws child prostitution, as seen in chapter five.\(^9\) As well as the international and regional human rights instruments discussed in chapter three, the law in Kenya defines a child as a person under 18 years of age.\(^10\)

In terms of education, the majority of sex workers in the study had at least gone to school, but their levels of education varied, with most dropping out in from primary education. While, the highest had O-level (Kenya Certificate of Secondary Education) qualifications, the lowest had dropped out of school in Standard II. The reasons for dropping out of school included difficulties in making ends meet and the loss of one or both parents.

The majority of sex workers were single parents. They had their own children, though some had ‘adopted’ children from their relatives.\(^11\) For example, Sex Worker 10, a 34-year-old, had ‘adopted’ three children of her deceased sister and was living with them. Two sex workers had grandchildren who lived with them as well as this 38-year-old

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\(^7\) Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).

\(^8\) Interview with Sex Worker 1 (Nairobi, 15 July 2015).

\(^9\) Sexual Offences Act 2006 (Kenya), Section 15.

\(^10\) Children Act 2001 (Kenya), Section 2.

\(^11\) Informal adoption in this case involves taking up the responsibility of a child or children of a deceased relative. This practice is common in Kenyan families.
participant said ‘I have four children and I have my daughter who gave birth when she was young and now I live with my grandchild.’  

6.1.2 The Reasons Why Women Start Sex Work

Historically, Luise White asserts that sex workers earnings have played a significant role for women sex workers and their families. These women have provided financial support to their families including husbands, children and other men who depended on them. While, for example, they owned property and rented it in the colonial city of Nairobi, majority of sex workers especially those interviewed in this research, are not involved in what White called ‘independent accumulation’. According to White, how a woman spends her earnings from sex work, nonetheless, explains something about why she became a sex worker in the first place.

When I asked the participants why they started doing sex work, they gave me varied reasons, including being orphaned. However, the primary reason was to fend for their children for a better life. They told me ‘I feed them [children] through this job of sex work’ and ‘I joined sex work because I had to fend for my children … I did not have other means … I joined … [to] feed my children, take them to school and get a better life.’ Another sex worker said:

I had to join because ... both of my parents died and I am the first-born in the family so I was going through many things. [I saw] the way [my] family also struggled to get me to Form Four. Those behind me had difficulties with schooling ... I saw it’s just a job like any other job because at least I managed to help our family a little and now I also have a son he has reached Form One and it’s still me who educates him just through this job.

In similar fashion, some sex workers questioned why women without children did sex work and wanted the police to leave them alone to conduct their business because they had children.

12 Interview with Sex Worker 6 (Nairobi, 15 July 2015).
14 Ibid.
15 Ibid.
17 Interview with Sex Worker 6 (Nairobi, 15 July 2015).
18 Interview with Sex Worker 7 (Nairobi, 15 July 2015).
19 Ibid.
Sex workers are seen to play a significant role in the society particularly in the education of their children. The Inspector of Police interviewed in the study remarked:

... You know some of these very big people are children of sex workers and they went to school because of that [sex work]. They have been educated because of that [sex work]. These women sex workers have really educated their children because of that one shot, two shots, [and] walking outside at night. Where do you want them to go? Should they not do [sex work], they would sleep hungry [and] their children would sleep hungry. In fact, they are playing a very big role.20

6.1.3 Sex Worker Hotspots

White asserts that many sex workers have in their lifetime practiced at least more than one form of sex work, even though they identify themselves with one.23 The oldest form watembezi translated from Swahili as ‘streetwalker’ could be traced from 1899 and agreement with their clients was negotiated in advance and away from the woman’s place of residence.24 The malaya sex workers, according to White, emerged around 1922 and the term came from the formal Swahili word for sex workers, who unlike watembezi, made agreement with their clients in their houses.25 White points out that ‘in reaction to … moralistic bylaws through which the British limited male and female mobility, banned prostitution, and barred unmarried female residents, malaya prostitution mimicked marriage and conformed to Nairobi civil law. As a result, its

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20 Interview with Sex Worker 1 (Nairobi, 15 July 2015).
21 Interview with Sex Worker 9 (Nairobi, 15 July 2015).
22 Interview with Inspector of Police (Nairobi, 10 July 2015).
25 Ibid.
practitioners were secretive and isolated from each other in their work.\textsuperscript{26} The wazi-wazi was another form of sex workers who were mainly the foreign women from the current Tanzania and Uganda and made their agreement with clients while they sat outside their houses.\textsuperscript{27} This study affirms White’s finding in the way sex workers who participated in the study said they conducted their business. In the City of Nairobi and much of other towns in Kenya, sex workers conduct their business in different places, including in their homes. KESWA representative explained it this way:

*Sex workers have different strategies. We have home-based sex workers ... their homes are their clients’ hotspots. We have street-based sex workers who leave their homes to go and stand on the streets ... no man knows their place [home]. We have venue-based sex workers ... they are categorised in different ways: those [sex workers] who go to hotels, those who go to clubs and those who go to big bars. There is a difference between a club and a bar. For example, Simmers is a bar ... Rumours is a club. There are those [sex workers] who work in brothels and clients go there for them.*\textsuperscript{28}

*... There’s a time you can go [to streets] also at night [and] you miss a client and stay in that cold which is still a problem for me because may be the cold in the night will bring me pneumonia and so it depends because at times it’s rainy season you cannot stay on the streets. So my job most of the time is at night in the bars.*\textsuperscript{29}

These different places of work are what sex workers in this study referred to as ‘hotspots’. Hence, while some sex workers had specific hotspots, e.g. Utamaduni and John Saga bars in Kariobangi and Huruma respectively or the streets, where they frequented to wait for clients, others such as Sex Worker 7 were ‘mobile’. ‘I’m mobile... Sometimes I’m found in town, sometimes I’m found in the neighbourhood, I mean everywhere for as long as I hear there’s a hotspot that has been opened and the clients are good, I go. Even now, if I’m called … I’ll go.’\textsuperscript{30} To be a mobile sex worker it did not mean having the mobile numbers of the clients on their mobile phones because they already had some numbers anyway, rather being able to move from one hotspot to another without any restrictions, e.g. Dandora, Kariobangi or anywhere else.\textsuperscript{31}

\textit{At times I am mobile but most of the time I am found at Kariobangi Shopping Centre. There’s a time you can hear about maize harvest in Eldoret [and] you’ll leave [Kariobangi] because business at that time is booming over there unlike here. May be in a day you can get like two clients [here] but when you go to Eldoret ... there’ll}

\textsuperscript{26} Ibid 257-258.
\textsuperscript{27} Ibid 258.
\textsuperscript{28} Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
\textsuperscript{29} Interview with Sex Worker 2 (Nairobi, 15 July 2015).
\textsuperscript{30} Interview with Sex Worker 7 (Nairobi, 15 July 2015).
\textsuperscript{31} Ibid.
be money at that time. There’s a time you’ll hear about fish [harvest] in Homabay or Naivasha ... there’ll be money there.32

6.2 Thematic Areas

This section presents two main themes important to understand sex work in the current Kenyan legal environment especially from sex workers lived experiences and other key stakeholders.

6.2.1 The Factors Promoting the Enjoyment of Sexual and Reproductive Health Rights

My research identified having better knowledge of sexual and reproductive health as rights, a constitutional enabling environment including demand-related voices as rights-holders as well as building their capacity through training for adequate understanding of their claims, as factors that contributed to the enjoyment of sexual and reproductive health rights of sex workers in Kenya. I analyse each of the factors in this section and argue that they are important for the empowerment of sex workers and vital to the health of women involved.

6.2.1.1 Knowledge of Sexual and Reproductive Health Rights

It is fundamental that women’s struggles from the global south are understood and women especially sex workers are able to articulate their sexual and reproductive health in terms of rights.33 Education on sexual and reproductive health rights is fundamental for sex workers, so that they know their rights and can participate fully in matters that affect them as rights-holders.34 Sexual and reproductive health rights are recognised as human rights that are as important to sex workers as they are to all people and they need to be protected. Ban Ki-moon remarked that ‘let us ensure that those people who most need their rights protected are made aware that this Declaration [Universal Declaration

32 Interview with Sex Worker 2 (Nairobi, 15 July 2015).
of Human Rights] exists – and that it exists for them. Ki-moon’s remarks suggest that knowledge is power especially for vulnerable and marginalised people.

When I asked sex workers what sexual and reproductive health rights meant for them, participants in the focus group said first of all that they had rights and that cited SRHR as their right to have sex, their right to have children, their right to use family planning and their right to protection to avoid unwanted pregnancy. These rights include not to be infected with sexually transmitted infections including HIV but also the right to receive medical treatment. Equally, the right to work and to be paid for sexual services offered and to non-violence or coercion. In one-to-one interview, a 28-year-old Sex Worker 9 said:

... Yes, I have rights. I am a human being like any other person. Everyone has rights ... I have a right to live even if I am doing that job [sex work]. I do everything for myself with that job [sex work]. I have the right [to health] because by the way those are many years [since 2001] to be doing sex work and [I’m]...healthy, [I] have not been infected with diseases. I normally tell my God thank you.

Another said SRHR means ‘my right when I go with a customer [he] must [use] a condom and [he] must pay me money … I do not like to be threatened just because I’m a sex worker” and another described SRHR as the right to health that involved the ‘treatment of the private parts’. Others explained SRHR in term of diseases that affected especially women such as HIV and syphilis and the right to receive treatment for them. It also involved the right to make voluntary and responsible decisions for their sexual life as this participant explained.

The first thing, it is a must when I sleep with someone for him to tell me if he will use a condom or will not use it. If he refuses to use [a condom], it all ends there because I have seen many of my friends have died of that disease [HIV] so I [don’t] want it and I [don’t] want my parents to know. Therefore, I have to protect myself.

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36 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
37 Interview with Sex Worker 9 (Nairobi, 15 July 2015).
38 Interview with Sex Worker 4 (Nairobi, 15 July 2015).
39 Interview with Sex Worker 3 (Nairobi, 15 July 2015).
40 Interview with Sex Worker 5 (Nairobi, 15 July 2015).
41 Interview with Sex Worker 9 (Nairobi, 15 July 2015).
Still some clients refuse to use condoms or are forceful even after they have agreed leaving sex workers at the risk of STI and HIV as well as pregnancy. Sometimes condoms break especially with aggressive clients. Aware of the risk of unprotected sex, they normally rush to a health facility for treatment.

*By the way, this job is not very nice because you can meet a mad person [aggressive client] you start to struggle with or the condom bursts. If the condom bursts, you have to be clever. If you are not clever to run to hospital, that disease will catch you. When the condom bursts, you run within 72 hours ... to be given the medication to prevent that disease [HIV].*  

It is important for sex workers to articulate their sexual and reproductive health rights including the link of SRHR to other human rights to understand what rights they have as human beings and how to make claims when their rights are violated. Knowing their rights will enable them to participate in comprehensive way. The representative of the Kenya Sex Workers Alliance put it that:

*The reason why these rights [SRHR] are important to sex workers is [because] a sex worker is a woman, a sex worker is a human being, a sex worker is a person like any other person. So, if all these rights are given to any other person, then as a sex worker they also have a right to have them. Because ... if we deny sex workers [the] right to sexual reproductive health, sex workers are at high risk of HIV infections and STI [and] ... it means that the HIV prevalence among sex workers and their clients will be twice [that of] the general population. So we are looking at them from two angles. First to help reduce the HIV prevalence, and also to sort of adore a woman, because a sex worker is a woman, remembering that a woman is the head of the society; without women ... nothing happens.*

It is not enough to have sex workers know their sexual and reproductive health rights, the public should be educated on these rights as well.

*... when we come to the rights, as much as they [sex workers] know their rights the public should also actually know those rights ... problems arise where these people [sex workers] know their rights but the public seems not to really recognise those rights or they refuse [to acknowledge them].*

There are several challenges in relation to implementing human rights in Kenya including the weak understanding of human rights in the public sector and the labelling
of human rights defenders and advocates as ‘dangerous’ and a threat to the state. Such attitude from the government that acknowledges HRBAs in its policies, I argue, encourages fear among human rights advocates of key populations and others from holding the government accountable and presents as Francisco Songane posits elsewhere, challenges for collecting evidence on the impact of HRBAs in the country.46

But then the challenge comes if you are doing something that is not well understood like in Kenya right now human rights is still believed [to be] a radical process ... The concept of human rights ... is not well understood by many people particularly the public sector. Once we talk about issues to do with rights, then sometimes, you look like an enemy of the state which can be dangerous. So it matters also how you package this issue [sexual and reproductive health] as a right ... You cannot come out strongly advocating for it. You must come out softly by the time they realise actually you have been addressing issues to do with rights. Because you know initially, the people who have been behind the quest for democracy in this country [Kenya], the quest for transparency, accountability, basically, were human rights watch-guards ... [this] was not taken well. So sometimes even a sitting government ... see people coming out strongly advocating [for] a rights based perspective, they look at them as threats. So that understanding, general understanding of rights ... in the country is still weak. So if you were to talk about human rights or sexual and reproductive rights for commercial sex workers you are presumed to be advocating for the vice and promoting it, more sensitively for MSMs [Men Having Sex with Men].47

Ignoring the key populations especially the sex workers puts their lives in the harms way. The representative of Bar Hostess Empowerment and Support Programme commented:

I am fighting for the rights of sex workers, it does not mean that I am recruiting sex workers or I am encouraging people to join sex workers. If you fight for good conditions for prisons, it does not mean that you want people in prisons. It is just accepting that there are people in prisons. If I fight for the rights of sex workers and lobby for good working conditions for sex workers it does not mean that I am encouraging people to join sex work. Those sex workers who are operating need their human rights, and reasonable working conditions, and it will in no way bring more people into sex work. But ignoring or punishing them, on the contrary, does more harm.48

47 Interview with Representative 2, Family Health Options Kenya (Nairobi, 23 June 2015).
48 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
6.2.1.2 The Constitution and the ‘Opened-Up’ Space

The constitutional changes in Kenya have provided a platform or space for not only legislative and policy development incorporating a human rights-based approach but also for advocacy work by NGOs. The new changes have been recognised. In the remarks by the previous Chief Justice and the President of the Supreme Court of Kenya, Justice Willy Mutunga, recognised the constitutional space in Kenya:

*The Constitution has created the space for the ordinary citizens and their representatives to litigate and compel the courts to create a new jurisprudence that tackles the structural inequalities that characterise our society. If appropriate cases are not brought before the courts and judges challenged to interpret the provisions of the Constitution, it will be many years before the full benefits of what was intended in its passage become reality.*

Although silent on sex workers, for the first time, the Constitution of Kenya 2010 places a strong focus on vulnerable and marginalised groups. As seen in chapter three, it has empowered Kenyans, including sex workers, to be able to bring their claims before the courts regarding the government’s failures, and further created an opportunity for the courts to make decisions on the impact of provisions of the Constitution on women. For example, for the first time ever, sex workers in Kenya submitted their shadow report to the 68th Session of the CEDAW Committee, drawing attention to numerous human rights-related issues, including the barriers to their sexual and reproductive health rights, e.g. stigma, discrimination and violence.

When I asked whether the 2010 Constitution had any effect on sex workers, some participants in the study acknowledged that they could see a difference. For example, the BHESP representative stated

*Yes, it has opened up the space and it gives us an opportunity to address the clauses that make sex work illegal. Sex work in Kenya is governed by the Penal Code. [A] woman living off the proceeds of sex work is criminalised. The new Constitution is silent. So we can ask for alignment and deleting of such Penal Codes that are not in*

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51 Ibid 370.
line with the new Constitution. Sex workers mostly get arrested under the County By-Laws [for] loitering and prostitution – loitering with intent of prostitution, [and] sometimes drunk and disorderly. So those clauses of loitering are not in line with the new Constitution. They have been proved to be old colonial laws targeting sex workers and bar hostesses.  

Where sex workers are arrested, the organisations on the ground have partnered with other human rights organisations, e.g. the Centre for Rights Education and Awareness (CREAW), to represent sex workers in court and to educate them on their constitutional rights as was explained.

So sex workers were educated on their rights in the Constitution, because we didn’t know how to interact with it and any time we were arrested, we were asked ‘why are you being arrested and charged with loitering? What evidence is there?’ So we were able to take about 35 of such cases to court and we won in all of them. The police could not prove that the girls [sex workers] were loitering. So we have that evidence on record and some of the cases that we hope to take forward to sue for unlawful arrest and to also challenge the Constitution and the Municipal By-Laws and avoid sex workers being arrested with loitering.

A previous Kenyan study documenting human rights violations of sex workers has shown that sex workers would plead guilty when arraigned in court so as to either be fined or imprisoned without wasting time. But the education on the rights that has come with the 2010 Constitutional space has encouraged the women who do sex work to stand up and challenge that law. To another extent, sex workers have found an opportunity to lobby the law makers both at the national and county levels to repeal the colonial provisions embedded in the Penal Code and implemented through County by-laws. However, the task is not easy, as BHESP representative explained that no County had tried to change their by-laws and that any attempts to do so were met with backlash.

No. One, it’s not popular because an MCA does not want ... you know they are looking for publicity, political mileage and supporting sex workers’ issues is not popular for them ... [It] will not give them marks [and] will be used against them during the elections. So on the contrary what they do is try to fix even stricter laws. What they try to do is mention that they are going to get rid of sex workers in their Counties. Trying to win populist votes; that we are going to make this County holy and pure. We are going to get rid of those women [and] we are going to clean the place is more popular with politicians than saying that sex workers are good people.

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53 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
54 Ibid.
because it’ll be used against them. They’ll be dismissed as ‘MPs for prostitutes’. They stand a risk of being ridiculed. 55

There’s a time in 2011 during Mayor Aladwa’s [time as Nairobi Mayor], ... he came up with a very progressive initiative after sex workers and MSMs had protested in the street over a City Council police beat up an MSM unconscious. So we all demonstrated and as a result a Task Force was formed to find out why we are having women in the streets, beggars, street boys ... but sex workers drew a big attention. It was a Task Force to find out what can be done, why are they [sex workers] here? What do they want? How can we make Nairobi a better place? He [the Mayor] said ‘it’s a social problem like any other, like hawking and that they [sex workers] are part of us we need to see how we are going to work with them. We suggest we give them a certain street and hours where they can operate freely without them being arrested or beaten up.’ I had seen decriminalisation right there. Decriminalisation just means we are legal and we are setting our own rules of how we are going to work but it was during the [election] campaign time. [The] Minister for Constitutional Affairs came in and said ‘please advise the Mayor that prostitution in Kenya is illegal’. So the next day he denounced. You know he’s also looking for political mileage, looking for political office. So that went down the drain. 56

Politicians in Kenya and much of the global South do not gain political mileage for supporting sex workers. They risk political suicide and are labelled for such support. Whether there is any interest in advancing sex workers’ sexual and reproductive health rights for example, the political game is to castigate sex workers as immoral, unworthy women making the streets dirty. While this would earn politicians the votes and hence positions in power, unfortunately such utterances leave sex workers more vulnerable to abuse in the society. On the other hand, the donor support towards sex workers programmes have been limited and impacted by the US policies which at the time of the interview were seen to favour LGBT community as was noted

... In my opinion as a sex work leader over the years I have found that as much as there’s sympathy from the public about female sex workers, there is more tolerance with partners and support towards gays such that there have been several gains. A transgender was allowed to change her names and her certificates and was passed [in court] that it was legal for her to do that. Gay, Lesbian Commission in Kenya took a case to court where they challenged the NGO board on registration of their organisation and they were permitted. A lot of lobbying at very high quarters can be matched by real dollars for the gay community. The same cannot be said for female sex workers. Maybe in my opinion the reason is that a lot of our partners [donors] will come from the US government which recognises gays, MSMs as a human rights issue as we have seen Obama recently. But have you heard him touch about sex work? None of those touch sex work because according to the US sex workers are victims. They do not see sex work as a human rights issue. They see it as poverty related issue, as trafficking issue and so supporting rights becomes very very hard.

55 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
56 Ibid.
Our support is very little and very far between from organisations like OSI [Open Society Institute]. It’s been a challenge over the years and our gains have been slow and painful.\(^{57}\)

But the platform for protection of sex workers’ and marginalised groups’ sexual and reproductive health rights provided by the 2010 Constitution cannot be underestimated as the Inspector of Police explained:

The Constitution has really captured these [rights] ... very nicely, and even when I talk [or] when I’m in the midst of people, I’m not scared to talk about anything concerning sex workers because the Constitution is more protective when it comes to the rights of every Kenyan, and it has not been discriminative in any way. I don’t see where it has discriminated [against] anybody. Not a sex worker, like men who have sex with men, female sex workers, the gays, the lesbians, the intersex, the transgender and many others ... So when you start talking about human rights you are not coming out supporting them but you are talking about their rights. We need to recognise their rights because they are entitled ... by our Constitution. So there’s nothing you can do to me when I tell you that this person is entitled to one, two, three, [because] the Constitution talks about it... \(^{58}\) [Laughter].

Yes, now there’s change. There’s no way a police officer will arrest you or will tell you that you are a prostitute, he must tell you why he has arrested you before you go with him. You have a right to know what he has charged you with ... before we used to be arrested, but without knowing what he has charged you with ... now it’s a must for him to inform you what you have been charged with or they will send you to [the] Occurrence Book to see what you have been charged with.\(^{59}\)

Participants in the focus group commented that ‘People [sex workers] are coming out right now. We can’t compare now and like 10 years ago. We were not ready to stand and say I am a sex worker. We had fear. We had stigma within the community.’\(^{60}\)

While the coming out can be attributed to the current constitutional environment, not everyone has the same view. Some sex workers think the 2010 Constitution has made no difference because of the way they are treated by the police and the Nairobi County Police (‘Kanjo’) who arrest them. In addition, the discrimination they encounter within the sex work community itself especially the older sex workers who feel the younger sex workers do not want to associate with them:

Things are just the same. In fact nowadays I don’t see people speak. (Clicks) ... In fact, I don’t see how that Constitution [has] helped because since it came, there are other places it presses you even when you [want] to speak you are [feel] pressed. A person doesn’t want to listen to you so it just forces you to keep quiet. Like let’s say

\(^{57}\) Ibid.

\(^{58}\) Interview with Inspector of Police (Nairobi, 10 July 2015).

\(^{59}\) Interview with Sex Worker 3 (Nairobi, 15 July 2015).

\(^{60}\) Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
... if you decide to go to the police, if you don’t have money they can’t be bothered with your issue. It just forces you to keep quiet. There are those that it [2010 Constitution] helps. Like me I am never called to projects if it’s not [mentions a friend] who comes to tell me ... that today there’s this and that for sex workers; people down here can’t call you for those projects. They discriminate you [and] I don’t know why? It’s those young ones [referring to young sex workers] they don’t want us to follow them up. They call us old prostitutes.  

6.2.1.3 Nothing for Us Without Us

In this Constitutional space, sex workers are using what Nnaemeka refers to as a ‘communal voice’62 to demand to be involved and consulted in matters that particularly concern them including on sexual and reproductive health rights. Many girls would have saved from HIV when it struck in the 1990s but according to BHESP representative,

There was no effort to address us ... and Bar Hostess really tried to push our agendas but we didn’t have enough support. The only HIV [programme] that was happening was ... in Majengo to see how sex workers will not spread [HIV] to other people. Nobody was thinking [how] the sex worker might be protected from HIV until the UN had to bring the evidence 10 years later? And it was because nobody was engaging us. So in that sense I can say we know the solution to our [problems] and we would like to be taken seriously. Sex workers have been in the forefront trying to address some of those social issues; issues of child prostitution, issues of poverty, issues of alcohol, issues of even families, issues of single motherhood, but we have never been given an opportunity, a key position, a decision-making or even be put at the table where such discussions are being held.63  

It has been said elsewhere ‘... to listen to the voice of the people is not a sign of weakness.’64 The women in sex work want to be ‘counted, not discounted’.65 When sex workers are involved, their plight is exposed. When they are ignored, policy decisions are often made which leave them vulnerable to the outcome of the processes that they have not adequately participated in. In a human rights-based approach, it fails to realise the fundamental principles of participation embedded in 2010 Constitution as

61 Interview with Sex Worker 1 (Nairobi, 15 July 2015).
63 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
65 C Smart, Feminism and the Power of Law (Routledge 1989) 141.
articulated by Ambreena Manji in section 2.1.1. For a long time sex workers in Kenya were ignored and they suffered particularly when HIV was most prevalent in Kenya in the ‘90s. Despite their experience, they continued with the struggle to have their voices heard as the BHESP representative accounted:

*In 1998 we came together as women working in bars to address customer violence ... at that same time HIV was declared a disaster in Kenya and we would come to this bar [interview venue] and find more than half of the women who were working just two months ago had died. Some went to die in the village but others moved to different estates. But when you looked around more than half had died. We went to another bar, everybody, 100 per cent of the women working in that bar who we knew had died from HIV, including the owner and the manager. It [HIV] was sweeping in the 1990s and everybody was so scared and just about two years earlier when we began to hear about it, we really didn’t believe because there was no information and the information could not reach people like us. And when it finally reached, a lot of us were already [HIV] positive and there was no medication. There was no help or even knowledge about the medicine, not to take alcohol, even we didn’t know about lifestyle changes. The stigma was high. So when someone started ailing they also started sleeping around even more.

*Because of the stigma you didn’t want to die alone and many things; bitterness. So it really hit us hard. Bar Hostess had been formed and we were referred to NACC [National AIDS Control Council] which had just been formed. They became our first partners ... they brought WOFAK and KENWA to come and talk to women in bars, ... talk to sex workers in the bars about HIV prevention. But even then the government did not recognise sex workers, bar hostesses, as key population. The HIV [advice] at that time was targeted to the general population. It was not like now where we are having special focus to special groups. We always look at it and I even tell NACC, you people did not listen to us. We tried to tell you early enough in 1998 that HIV was higher in the bars than it was in the general population. If they had listened! The evidence was informed by UN 10 years later in 2006/2007 when they started the focus on key population. But even then ... HIV continued to strike.*

*Now there has been an effort [to involve sex workers] ... and I can say we have made many strides because now we are part of the National AIDS Control Council’s Technical Working Group, [and] work with NASCOP [National AIDS and HIV Control Programme]. I can say largely we have finally been involved. But Bar Hostess played a very key role in having sex workers engaged at that level from those days. [We] even have the name of Bar Hostess in the Kenya National AIDS Strategic Plan.*

But this is not far from what Bartley’s study has shown in chapter one where historically, dealings around sex work did not focus on the safety of the sex worker, rather on the safety of the men they went with. I would argue that the problem is still

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67 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
68 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
evident in today’s Kenyan society as in much of Africa and that postcolonial Kenyan government has to pay attention to this marginalised group as promised in its 2010 Constitution.

Networking with fellow sex workers-focused organisations at the national and international level play a significant role in the empowerment of sex workers as a group to fight for their rights. Sex workers find power and strength in working together as a group and recognise that to fight for their human rights and entitlements they must support each other. KESWA representative told me ‘We believe working in groups makes people stronger than working with one person. In a group you can have a voice, but one voice is never heard,’\(^\text{69}\) and representative of Highway Community Health Centre also commented that: ‘What I can say about sex workers around here [Mlolongo] and all our other sites is that they are so strong together… They know that the government will never fight for them so they fight for each other… You cannot mess with them.’\(^\text{70}\)

Sex worker community across the globe including in Kenya come together on the International Sex Worker Rights’ Day observed annually on March 3rd and on the International Day to End Violence against Sex Workers on December 17th. They take to the streets to campaign for their rights and celebrate the struggles of sex workers and to show they are human. On these days, sex workers speak up of their experiences and raise awareness about violence committed against them, remember the victims of violence and call for punishment of the perpetrators including standing up against stigma and discrimination.

...We have celebrated our International Day ...to fight violence against sex workers in Nairobi, also in Mombasa, and it has an impact because when people see us on the streets with banners and shouting aloud that we are human beings, [and that] we do not want to be killed, we deserve to live, we are mothers who want our children to have a family, ... people listen to us, and they respect sex workers...\(^\text{71}\)

Sex workers come from all walks of life ... and use the Day to show visibility; to show the human face of sex workers; to lobby for the rights of sex workers; to join in [the] community; to put it in the face of people who want to pretend that such things do not exist; ... to lobby [for public] support; to remember sex workers who have been

\(^\text{69}\) Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
\(^\text{70}\) Interview with Representative of Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
\(^\text{71}\) Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
I agree with Cornwall and Nyamu-Musembi when they say in theory that ‘rights talk was, and remains, a defining feature of resistance and liberation movements.’ This study has shown that indeed sex workers in the global south are framing their rights as rights-holders to be respected and treated with dignity as human beings irrespective of the work they do. This indicates that ‘power within’ helps women to resist suppression. Thus, I agree with Cornwall’s description of empowerment. That empowerment is when ‘women recognise their power within and act together with other women to exercise power to act as agents; when they act in concert to tackle injustice and inequalities, this becomes ‘power for’ positive social change.’

6.2.1.4 Capacity Building

Human rights-based approach focuses on the marginalised and those who are often subject to human rights violations. To do this, capacity building is important for both the rights holder (sex workers) and the duty bearer (the Kenyan government). Building capacity for NGOs who work with sex workers in terms of funding and enhancing their human rights monitoring skills provides them with the ability to monitor sexual and reproductive health rights of this marginalised group. Sex workers and the organisations working with them noted that building the capacity of sex workers in terms of their sexual and reproductive health rights played an important role in their lives. ‘There was a lot of stigma, many deaths … HIV infection was high because of the multiple sex partners… Every weekend it was burying and burying and burying.’ Capacity building through training, for example, as paralegals and awareness creation empowers sex workers to engage in the dialogue and hold the government accountable. They recognise the power within them, to own their own health as well as sexual and reproductive health and in the words of Audre Lorde ‘to transform their silence into language and

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72 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
75 Interview with Representative of Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
In so doing, they also borrow good practices from fellow sex workers across the borders to ensure that sexual and reproductive health goods, services and facilities are sex workers’ friendly.

Based on the capacity building we have done for the longest time we have been here [in Mlolongo], there’s no sex worker who can agree to have sex without a condom. [This is] out of their own discretion. I have issues when there are no condoms [in supply], they will come and complain and I will tell them to go buy because you cannot have sex without a condom. These HIV projects have been there for so long we need to see impact and, that is impact. We need to see what is the effect ... you cannot be attending trainings every time, enrolled to a programme and you have no idea on what to do. So what you do will make you responsible to teach others. Therefore, we didn’t expect anything different from them.77

We have reached 38 Counties where KESWA has done capacity-building of sex workers and we have groups of sex workers in the 38 Counties who are empowered and ... operate on their own ... We have identified the other nine Counties but the challenge is, some are faced with cultural, social and religion challenges. So they ... do sex work under denial that they are not sex workers but they are Muslim women. Another challenge is that you cannot go undercover because we, as KESWA, if we go there and say we are for women’s rights then there are other women’s rights organisations on the ground. That’s why we want sex workers to identify themselves. Like the Laikipia, the Nyamira and [the] Nakuru groups that we have, they also had that fear but once they came to our capacity-building for five days they went back very empowered. They even called us to go and train more sex workers there. And now they can come out and they can speak on their own.78

There has been a lot on reproductive services. Bar Hostess, have two clinics ... Our clinics are run by sex workers community itself ... [and] funded through Global Fund. We are learning – India is such a good model where [the] sex workers community are running their clinics. So these are very huge attempts to be able to follow that model.79

One thing is [that] most of our sex workers do not know their rights and [so] sensitisation or training is very important, especially paralegal training.80

... Now BHESP have ... paralegals who follow up cases. Even now when a client refuses to pay you, there’s a paralegal who will follow up and they have lawyers to help us. But before that ... we were really suffering.81

The quotations above suggest that sex workers in Kenya as in other parts of the global south e.g. India are training and educating themselves to increase their knowledge and understanding of their rights including sexual and reproductive health rights. They are

77 Interview with Representative of Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
78 Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
79 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
80 Interview with Inspector of Police (Nairobi, 10 July 2015).
81 Interview with Sex Worker 3 (Nairobi, 15 July 2015).
educating themselves so they can fully participate in the matters that concern their lives including violence as articulated in section 3.2.1.2. The focus group recounted one notorious client. The client negotiated sexual services to be offered between him and the women but when they reached his house he would make them ‘wives’ to the dogs. They were subjected to have sex with his dogs. The new sex workers on Koinange Street in Nairobi were particularly his target.

There is [a client] on Koinange Street [he] used to carry us and take us to his dogs. The client was called X. When he comes, he looks for those new girls who do not know him. You are carried ... and you know that X has good money. But when you get there it is his dogs that are going to fuck you or [you find] many men are full in the house. We ganged [up] against X on Koinange Street and we beat him like a snake.82

Client X was eventually reported to the police and he was arrested with the efforts of paralegal sex workers.83 He was still in custody at the time of this interview. Non-governmental organisations also use peer-to-peer education, e.g. peer-to-peer sex workers do outreach work, referrals and advocacy with fellow sex workers.84 Family Health Options Kenya explained their peer education in prisons:

We also generate a behaviour change programme within the prisons, where we have peer educators within, who become champions to counsel, educate and share information with other prisoners inside. So we literally try to build the capacity of the prison institutions to be able to address SRHR issues internally, within the prisons, with external support from us as NGOs, and trying to link them also to the public-sector health institutions.85

Sex worker 3 also a peer educator said ‘I distribute condoms to our fellow peers [sex workers] … [and] these papers that normally have information [IEC materials] … they have information like on STIs and things like that … when someone has a problem we refer them to the clinic. Like now us we work with BHESP we refer her [sex worker] to Jogoo Road or here in Kariobangi roundabout, there’s a clinic.’86 But dealing with sex workers goes beyond distributing condoms, as this participant explained

Because we realise just giving them tablets does not mean that they [sex workers] will swallow [them], it does not mean that a tablet is the end of all your problems. There should be motivation. You find in some places someone can be HIV positive, they know where to get the ARVs and they are not taking [them], so we should find out why. They know where to get condoms, they know condoms will prevent HIV, [but] they are not using [them]. So we cannot just distribute condoms and we do not

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82 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
83 Interview with Sex Worker 3 (Nairobi, 15 July 2015).
84 Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
85 Interview with Representative, Family Health Options Kenya (Nairobi, 23 June 2015).
86 Interview with Sex Worker 3 (Nairobi, 15 July 2015).
address their environment and psychosocial issues that are preventing sex workers using those condoms, the legal environment, the violence that is there.\textsuperscript{87}

To empower sex workers economically, KESWA and BHESP started micro-saving initiatives to ‘improve support for them so that they can be able to substitute with whatever they are earning in the streets’\textsuperscript{88} and also so that ‘we have a happier community.’\textsuperscript{89} The representative of KESWA emphasised that the extra income was not meant for sex workers to leave sex work but to expand their sources of income so that they do not solely rely on sex work.

\textit{Maybe with time, [probably] five years down the line, we want a sex workers’ Bank that will be operational, [so] that sex workers can get loans, sex workers can have their own buildings [and] they can have their own matatus [local buses]. This is a way of doing economic empowerment for sex workers. We are generating optional incomes, not for people to leave sex work but for when they feel like today I’m not feeling ok, they still have something else that they can draw money from, not only depending on sex work directly. That’s one thing that we want to change and we thank the Constitution now we can associate together with other people [Global Network of Sex work Projects].}\textsuperscript{90}

It is not enough to build the capacity of sex workers on sexual and reproductive health rights. The government health workers have to be equipped with sexual and reproductive health rights education to provide respectful and dignified sexual and reproductive healthcare for sex workers and all women as provided in the 2010 Constitution and health policies. The policy maker in the study indicated that ‘… in training we are really focusing a lot on the vulnerable population, so we hope it is a step in the right direction.’\textsuperscript{91} But personal beliefs of healthcare providers remain a challenge. FHOK representative 2 citing a situation where a health provider had said that ‘her heart had completely refused to accept key populations especially LGBT people,’\textsuperscript{92} was emphatic that culture, religion and socialisation continue to impact negatively on sexual and reproductive health rights of key populations and that there was need for value clarification to change the negative attitudes towards them. The policy maker commented:

\textsuperscript{87} Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
\textsuperscript{88} Ibid.
\textsuperscript{89} Ibid.
\textsuperscript{90} Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
\textsuperscript{91} Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 July 2015).
\textsuperscript{92} Interview with Representative 2 of Family Health Options Kenya (Nairobi, 23 June 2015).
... at some level health workers still have their personal beliefs such that you know you are supposed to give everybody equal treatment, but then in practice there’s a lot that comes in the way, including your own personal beliefs, norms and cultures in the society and this needs I think a lot of training and mentoring.  

At the time of my fieldwork, I was told that to ensure dignified care to everyone, the government was in the process of developing dignified care indicators although this, the policy maker indicated was a challenge in and of itself. Irrespective of the hurdles including the fact that health-related care do not have instant solutions, the policy maker pointed out that the government was ‘to ensure that Kenyans have the best care even if not now in the long run’ and that ‘we just need to make sure that we have systems in place that constantly observe dignity for the patient.’

6.2.2 The Factors Hindering the Enjoyment of Sexual and Reproductive Health Rights

This section is concerned with the factors that hinder sex workers in Kenya to enjoy their sexual and reproductive health rights. Maggie O’Neill has argued that despite the flexibility that accompanies sex work and the offer for independence and autonomy, women engaged in sex work face varied challenges. These, for example, are fear, violence, criminalisation, the risk of sexually transmitted infection and even seriously, death. This research confirms that sex workers face a myriad of challenges that have severe impact on their sexual and reproductive health lives. If the Kenyan policies are rights-based as this thesis has shown they claim to be, at least in text, I argue, that the Kenyan government has to address the barriers that women who do sex work face. In so doing sex workers will be able to enjoy their fundamental right to the highest attainable standard of physical and mental health guaranteed in international human rights treaties discussed in chapter three and in national laws and policies in chapter five.

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93 Ibid.
94 Ibid.
95 Ibid.
96 Ibid.
98 Ibid.
6.2.2.1 Underfunded Health Sector

Many poor and middle-income countries, Chapman et al. point out, choose not to invest sufficient public resources in health, while the majority of more affluent countries fail to fulfil their core extraterritorial obligations to provide sufficient amounts of international assistance to enable resource-deprived countries to fund their health entitlements.\(^\text{100}\)

Although international assistance for health has increased in recent decades, Chapman et al. argue, it is still considerably less than the United Nations standard of 0.7 per cent of gross national product (GNP).\(^\text{101}\) The assistance rendered is mainly for specific programmes, e.g. malaria and HIV and AIDS treatment, and not, it is argued, for strengthening health systems.\(^\text{102}\) African states have called upon donor countries to complement their resource mobilisation efforts, ‘bearing in mind that Africa cannot, from its weak resource base, provide the huge financial resources needed.’\(^\text{103}\) Lack of sufficient spending on health is a problem in many African countries. According to Durevall and Lindskog, things will only get worse, especially with the uncertainties surrounding the future financing of HIV treatment programmes and the reluctance on the part of donors to increase funds, considering the decrease in commitments targeting HIV and AIDS.\(^\text{104}\)

The budget allocation to the Kenyan health sector is well below the 15 per cent agreed upon in the Abuja Declaration at the African Summit on 27 April 2001 in Nigeria.\(^\text{105}\) With the changes in the 2010 Constitution, the devolution of the function of health to the 47 Counties is even more confusing as the healthcare provider noted that

... the government has never increased the health budget. It has always been between 4 per cent to 8 per cent. There is confusion between devolution of health services because the County governments are not able to purchase commodities. There is a

\(^{102}\) AR Chapman, L Forman and E Lamprea, ‘Evaluating Essential Health Packages from a Human Rights Perspective’ (n 90)
\(^{103}\) African Summit on HIV/AIDS, ‘Tuberculosis and other Related Infectious Diseases’ (n 90).
challenge about purchasing … family-planning commodities and also providing services to all women, let alone the sex workers.\textsuperscript{106}

In addition to the underfunding of the health sector, the Family Health Options Kenya representative noted that the lack of technical input in the development of health sector has, on the contrary, brought a lot of challenges, too, in the public-health sector.\textsuperscript{107} These challenges, coupled with incoherent policies, result in inefficient provision of sexual and reproductive-health services to sex workers.\textsuperscript{108}

6.2.2.2 Ambiguous and Confusing Policies

In a human rights-based approach, sexual and reproductive health rights-related laws and policies need to be transparent as well as easy to understand and the government has to be accountable in implementation. In situations where the law is not clear, implementation is equally a problem. Representative 1, from Family Health Options Kenya, had this to say about Kenyan laws:

\begin{quote}
I think a good policy is a policy that is responsive to the needs of the people. We have blanket policies. They are too general in the way they have been framed. They are not specific. They do not highlight specific issues they are addressing. They are just blanket policies, in the sense that they are misinterpreted, misused, misapplied and depend on the prevailing environment in terms of application, which is also a danger because it puts a lot of fear in the general population. They [laws] contradict each other. While one will appear to be pro a certain issue there is always another law in place that counters that. So you will find that in terms of actualising these laws and providing services, there is no clear path regarding which direction we are supposed to go, literally, as service providers, programmers or people in the development field.\textsuperscript{109}
\end{quote}

Participants in this study were concerned with the way reproductive health policies were passed and shelved, and that the public in general, more so, women including the police had very little information regarding for example, the circumstances under which abortion was allowed in Kenya under the 2010 Constitution as seen in Section 3.3.2.

\begin{quote}
The government is just putting them on the shelf … they are not effective … Reproductive Health Policy, Adolescent Health Policy, all those policies are there, but they are not followed... The public is not aware, law enforcers are not aware of the provisions of the Constitution and so … most of the health workers are harassed
\end{quote}

\textsuperscript{106} Interview with Health Care Professional (Nairobi, 25 June 2015).
\textsuperscript{107} Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
\textsuperscript{108} Ibid.
\textsuperscript{109} Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
by police and there is a lot of stigma because of lack of information and misinterpretation of the Constitution because some people feel that provision of abortion services is illegal in Kenya, which is not true.\textsuperscript{110}

This does not only suggest that sex workers are in a dilemma with the confusion in implementation of the 2010 Constitution and the reproductive health policies in place, but that the colonial abortion laws as stipulated in chapters one and five have had a significant impact in practice. The healthcare providers’ lives are threatened. They fear police arrests and at times, their clinics are vandalised or even burnt down. In addition, efforts were made to establish a legal support network to support providers of reproductive health. Citing a 2013-14 study, the healthcare provider pointed out that approximately 465,000 unsafe abortions occurred in Kenya and that the most affected are poor women who go to quacks while the rich women can afford good reproductive health services including safe abortion. The Kenya Health Policy acknowledges unsafe abortion as a major cause of maternal mortality\textsuperscript{111} However, some efforts are underway to prevent all these unsafe abortions, as the healthcare provider stated:

... we are trying to work on medical abortion whereby women can manage themselves without necessarily going to hospitals. We call it community-based access to misoprostol and there are some organisations also which are training community nurses to distribute misoprostol to women.\textsuperscript{112}

This harm-reduction model, as the healthcare provider informed this study, discourages women from using sticks or hangers to perform life-threatening abortions because:

... they can go buy those medicines in the chemists and they swallow them and then start bleeding. If the pregnancy does not come out they can go to the hospital... We are trying to educate women so that they can do that before nine weeks, that is, one or two months ... that is the safest ... the bleeding is minimal.\textsuperscript{113}

\subsection*{6.2.2.3 The Criminal Law and Sex Workers}

It is evident in this study as showed above that sex workers know their sexual and reproductive health rights, but, sex workers in Kenya as elsewhere in Africa barely know the legal status of sex work in their own countries and the lack of awareness of

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{110} Interview with Health Care Professional (Nairobi, 25 June 2015).
\item \textsuperscript{111} Kenya Health Policy 2012-2030’ (Kenya) 66.
\item \textsuperscript{112} Interview with Health Care Professional (Nairobi, 25 June 2015). Post abortion care is provided in the Kenya government hospitals.
\item \textsuperscript{113} Interview with Health Care Professional (Nairobi, 25 June 2015).
\end{itemize}
\end{footnotesize}
laws and policies that affect them only serves to instil fear, anxiety and uncertainty in the lives of women involved in sex work.\textsuperscript{114} For example, a study in Ethiopia revealed that levels of understanding of the legal status of sex work varied amongst sex workers.

\textit{Some suggested that sex work could not be illegal because, if it was, it could not be practised openly without police interference. Some incorrectly thought that conducting another trade alongside sex work, such as waitressing, means that the laws against prostitution do not apply. Others said that they had been told that there are licences that exempt some venues from laws concerning brothel keeping and living off immoral earnings (there are no such licences). However, many participants had an accurate understanding that there are some laws against soliciting and brothel keeping. Most said they were aware that it is illegal for minors to sell sex and for others to exploit children sexually.}\textsuperscript{115}

Explaining their understanding of the law on sex work, sex workers in the focus group pointed out that it is the money they are paid that makes the police jealous of their income, since they are not arrested because they have been found exchanging money, and neither are they arrested because they are found in the sexual act. They are just arrested when found standing at the bus stop, in their neighbourhood or on the streets. The problem with the police, they said, is they ‘judge from dressing’.\textsuperscript{116} They claimed police harass them, wanting free sex without a condom. To be released, a ‘police officer will want to have sex with you standing in that corner without a condom’,\textsuperscript{117} indicating some sex workers keep quiet about such incidents because they are not sensitised to insults from police and they said ‘when you walk in town without a man you are [labelled] a prostitute,\textsuperscript{118} as well as ‘when a man walks with two women he is asked, which one [of them] is yours? The other one is arrested.’\textsuperscript{119}

And although sex workers said being arrested for carrying condoms had gone down, arrests would be made ‘when you are found carrying condoms\textsuperscript{120} because ‘you are [said to be] a prostitute’.\textsuperscript{121} The sex workers in the focus group thought a debate with the police would be helpful so they can ask the police directly why they arrest them

\textsuperscript{114} C Overs, \textit{Sex Workers, Empowerment and Poverty Alleviation in Ethiopia} (Institute of Development Studies 2014).
\textsuperscript{115} Ibid 18.
\textsuperscript{116} Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
\textsuperscript{117} Ibid.
\textsuperscript{118} Ibid.
\textsuperscript{119} Ibid.
\textsuperscript{120} Ibid.
\textsuperscript{121} Ibid.
carelessly, yet even university students dress worse than them. Sex Worker 2 asked the police to stop arresting them when they find them in possession of condoms because she noted: ‘…we have a right to protect ourselves because the moment I will go out there and get AIDS, it [would] still [be] the government’s duty to [provide] for me the medication that I would take.’

Less than 15 miles from Nairobi and the experience of sex workers and the police is different. In an interview with a representative of the Highway Community Health Resource Centre, an organisation that targets truck drivers but by proxy facilitates healthcare services to sex workers, the respondent stated that ‘…being a sex worker is not a problem today because even the people who are arresting them are their clients.’

In fact, sex workers do not encounter harassment from Mlolongo sites, probably because they do not have street-based sex workers. The respondent dismissed the arrests by police as just a show. The kind of violence and harassment that sex workers encounter on their sites is from clients, particularly those who refuse to wear condoms, not from the police. The sex den in Mlolongo was described as one building that has 50 rooms, typically for sex. Anybody who goes there goes for sex. It is a well-known fact that the police are around the corner but do not go there to arrest sex workers. In fact, in the same week as the interview, a chief had scheduled a meeting with the sex workers to discuss their issues. The respondent cited an old incident when a group of angry sex workers frog-marched a client to their health centre demanding they publicly test the client for HIV because they claimed he had raped a fellow sex worker. The centre declined to do the HIV test for consent and confidentiality reasons. The police came to disperse the angry sex workers, but they almost beat up the police too. The policy maker described this action as coming from ‘information-driven, rights-driven approach.’

Without government support, sex workers have learnt to fight for themselves, as per the interview with the representative of the Highway Community Health Resource Centre noted above. Interestingly, sex workers are not only treated as criminals but, also seen

122 Interview with Sex Worker 2 (Nairobi, 15 July 2015).
123 Interview with Representative, Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
124 Sex workers hire the building and they contribute about 200 Kenya Shillings each (approximately £1.50).
125 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 July 2015).
as useful informers of the whereabouts of criminals. Improving the relations between the police and sex workers is seen as a good ‘crime-control strategy’: as a police officer indicated:

... when it comes to the police, they [sex workers] can be of great help. These people are friends to the thugs, to criminals, and if you are close with them they will always tell you information about these people [criminals] ... and that makes the environment safe.  

I would argue that care should be taken with such views as they do not serve the interest of sex workers and suggest instead that sex workers are linked to criminals. This has its implications; it makes women in sex work susceptible to further abuse.

On the contrary, fear of the police will always make sex workers run from the police and even fear to go for treatment, and voluntary counselling and testing, which in return will be a risk to communities. Police officers take advantage of the law to sleep with sex workers, many of them have even died of AIDS, and the police officer in this study argued that allowing sex workers to access public health services would equally empower sex workers to protect themselves. The respondent argued that legalisation or decriminalisation will reduce human rights abuses directed by police towards sex workers, and the rate of crime will come down. The respondent also argued that while awaiting changes to the criminal law, it is important for both the Kenya police and municipal city police (‘Kanjo’) to be trained on the Constitution and human rights, because the Constitution is protective of the rights of every Kenyan, irrespective of whether they are sex workers or not. It would reduce the violence inflicted on sex workers by law-enforcement agencies and reduce the enmity between the police and sex workers.

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126 Interview with Inspector of Police (Nairobi, 10 July 2015).  
127 Ibid.  
128 Ibid.  
129 Ibid.  
130 Ibid.  
131 Ibid.
6.2.2.4 Bribery and Police Harassment

Backed up by anti-prostitution laws, Okal et al., have found that police harass, threaten, arrest, beat and sexually coerce sex workers.\textsuperscript{132} In return sex workers feel reluctant to report cases because they find it quite pointless to seek justice against their perpetrators.\textsuperscript{133} This research found that not all sex workers who are arrested are arraigned in court. Some buy their way out. This entails bribing the police or having sex with them and thus avoiding the long process of being taken into police custody and appearing in court on charges of being drunk and disorderly or loitering with intent to prostitute. In court, the charges are read to sex workers and they plead either guilty or not guilty.

Nowadays, as sex workers explained, they plead ‘not guilty’, unlike before when they obviously pleaded ‘guilty’ because they did not understand the criminal procedure that it was up to the prosecution to prove their case beyond reasonable doubt. Instead, they preferred to be convicted, serve their one-week, two-week or one-month sentence, and move on with their lives. When asked if any of them in the focus group had been imprisoned, one participant responded ‘no’,\textsuperscript{134} and another added ‘we win all our cases because they have no evidence’\textsuperscript{135} [group agreement]. In fact, another participant stated, ‘which police will leave his work of going to eat a bribe to follow that case? No one. They never come. They cannot.’\textsuperscript{136} NGOs as discussed above engage the services of pro bono lawyers to represent sex workers in courts and train sex workers as paralegals to educate fellow sex workers on the legal process.

6.2.2.5 Violence against Sex Workers

The concern of postcolonial and human rights in the study focuses on sex workers as victims of violence and aim to ensure that a rights-based approach help in addressing the injustices against sex workers. Violence against women as seen in chapter three is defined by the 1993 United Nations Declaration on the Elimination of Violence against Women (DEVAW) as ‘any act of gender-based violence that results in, or is likely to

\begin{itemize}
\item\textsuperscript{132} J Okal, MF Chersich, S Tsui, E Sutherland, M Temmerman and S Luchters, ‘Sexual and Physical Violence Against Female Sex Workers in Kenya: A Qualitative Enquiry’ (2011) 23:5 AIDS Care 612.
\item\textsuperscript{133} Ibid.
\item\textsuperscript{134} Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
\item\textsuperscript{135} Ibid.
\item\textsuperscript{136} Ibid.
\end{itemize}
result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.\textsuperscript{137} Scholars contend that the promulgation of the United Nations’ Declaration on the Elimination of Violence Against Women, in 1993, constituted, they state, ‘a significant measure in the struggle to project the issues of gender violence onto the international arena as a human rights issue,’ and illustrates the ‘level of seriousness’ with which it is to be addressed\textsuperscript{138} particularly health-related violence.

Studies have shown that women, especially female sex workers in Africa and other parts of the world are vulnerable to violence.\textsuperscript{139} Besides, the prejudiced attitudes of health providers and the police, who tend to blame women for the violence, discourage women from seeking health care including sexual and reproductive health services or reporting the incident.\textsuperscript{140} Gender-based violence remains widespread in the eastern and southern Africa regions – about one in two women in the region has experienced physical or sexual violence.\textsuperscript{141} HIV is not the only risk that sex workers face in their work, they are faced with violence and discrimination too.\textsuperscript{142} Violence has profound effects on women’s sexual and reproductive health rights.\textsuperscript{143} It affects their health and the quality of their lives.\textsuperscript{144} Studies reveal that there are deeply entrenched structural factors that influence violence against women, plus the risk of HIV, which impedes the efforts to prevent HIV infections and the enjoyment of sexual and reproductive health rights.\textsuperscript{145} A rights-based approach is crucial to improve the health and lives of sex workers.

\begin{itemize}
\item \textsuperscript{137} United Nation Declaration on the Elimination of Violence against Women 1993, Article 1.
\item \textsuperscript{139} OI Fawole and AT Dagunduro, ‘Prevalence and Correlates of Violence against Female Sex Workers in Abuja, Nigeria’ (2014) 14:2 Africa Health Science 299.
\item \textsuperscript{140} L Tavara, ‘Sexual Violence’ (2006) 20:2 Clinical Obstetrics and Gynaecology 395.
\item \textsuperscript{144} Ibid.
\end{itemize}
The private nature of the violence experienced by women renders it invisible and therefore less likely to be reported. Additionally, the lack of witnesses to such private violence makes prosecution even more difficult. Sex workers experience violence at the hands of various people, ‘bar managers, bouncers, general public, taxi drivers, DJs, clients – highest violence, the partners of sex workers because some of them are in relationships, and … pimps.’ They experience different forms of violence. For example, they are alienated socially for who they are as well as economically and physically. ‘She will go, she will sleep with a man and she will not be given the money. In the course of that, when she’s trying to get her dues, she will be attacked physically.’

When asked what violations they encountered from clients, the focus group said:

FGD: Assault.
FGD: You find a person refuses to pay you.
FGD: Gives you fake money.
FGD: Sleeps with you and snatches the money including the one you already had and still beat you.
FGD: Another one wants to use all styles on you because he’s paying you.
FGD: or maybe you have agreed to use the penis and him he wants your buttocks also breasts.
FGD: Another one - I got into his car we talked and we did not agree I just heard loud sound on the automatic car doors. Me I didn’t see him open the door but I just heard a sound ‘gudum’. He just did this (demonstrates the way the car door was opened) and threw me outside the car while it was moving on Peponi Road in Westlands. I was found by police - I don’t know their station.

While sex workers noted that the arrests because of carrying condoms had reduced, the findings show that, however, sex workers are assaulted when they refuse to engage in sexual activities without condoms. Sex workers said that some clients have big penis and that they would beat the sex workers if they refused to have sex with them. Participants in the focus group narrated how a client once threw her out of a moving car at 2 a.m. on a lonely road because she refused to do a ‘blow job’ for him without a condom. She was hurt. She tried to stop other vehicles for help but none stopped. She

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147 Ibid.
148 Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
149 Interview with Representative 2 of Family Health Options Kenya (Nairobi, 23 June 2015).
150 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
said that she was lucky to have been saved by a police car on patrol which as she explained, did not arrest her but ‘dumped’ her in casualty at Kenyatta National Hospital.

Notwithstanding the terms of agreement, participants in the focus group revealed that some clients subjected sex workers to group sex without condoms. They said ‘You get into a place [client’s house] and find about fifteen fellow sex workers, what will you do and [yet] you want that money? But that was in those days,’\(^{151}\) and this when they stressed, ‘before we knew our rights.’\(^{152}\) They narrated how the client would gather fifteen sex workers in one night in his house and have sex with all of them. They explained in the focus group that he ‘gets into this one and out’ without a condom and then ‘he ejaculates in the last person’ or in the ‘one he felt was sweeter than the rest’. After such experience, sex workers said they would rush for post-exposure prophylaxis (PEP) treatment at clinics such as the Sex Workers Outreach Programme (SWOP) to prevent HIV infection. Before PEP came sex workers said ‘we used to buy lemon you squeeze it in water … and you use to wash your vagina. Imagine that lemon is what you want to put inside there to remove the germs,’ and that ‘you would enter the bathroom and put your fingers inside there.’\(^{153}\)

To avoid getting into the hands of abusive clients and risking their lives, sex workers came up with strategies to keep themselves safe. One safety measure they said was that they avoided clients’ homes or clients’ choices of where to sleep. Where a sex worker ends up with a client in any of his places of choice, she has to send a text message to at least a fellow sex worker to inform her of her whereabouts. Another measure is that sex workers pay security guards at different lodges or hotels to ensure that when they go into a room with a client, the client does not walk out alone or if security guard heard a sex worker scream in the room, the guard would rush to check on her. For the sex workers to come up with such a measures it was because ‘… our friend was killed and then we saw this is serious and because … the police are not on our side.’\(^{154}\) Having regular clients is not totally safe either. They may even murder sex workers, especially if they are relied upon for school fees and different bills which make them think they

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\(^{151}\) Ibid.  
\(^{152}\) Ibid.  
\(^{153}\) Ibid.  
\(^{154}\) Interview with Sex Worker 3 (Nairobi, 15 July 2015).
are the only ones in the relationship.\textsuperscript{155} The Bar Hostess Empowerment and Support Programme started as a group of women working in bars to address customer violence. Abuse happens to women working in bars as well as sex workers. The BHESP representative sought to explain the thin line between these two:

\textit{But every time the abuses were happening [it was] not only to the women working in bars, but also to sex workers who were operating in these bars. If you come here in the evening you are going to see some women will just be hanging around. They will not necessarily be bar hostesses ... sometimes when these girls [bar hostesses] also lose their jobs they become sex workers and some sex workers will also do bar-hostess work so that they can get clients. So, there’s a thin line...}\textsuperscript{156}

The list of perpetrators who use violence against sex workers includes family members, too, who, in most cases, sex workers hide from and they are not aware that they are doing sex work. The Kenyan government has a duty to protect sex workers as rights-holders, against violence from the public or private individuals. To fulfil its commitment to respect, protect and fulfil sexual and reproductive health of this group, the government must take its responsibility seriously, including the elimination of stigma and discrimination.

\textbf{6.2.2.6 Stigma and Discrimination}

The stigma and discrimination surrounding sex workers is well documented.\textsuperscript{157} Studies show that societal discrimination and lack of respect of fundamental human rights directly affect the health status of women.\textsuperscript{158} African women engaged in sex work experience deep societal stigma and discrimination that affect their ability to advocate their own human rights\textsuperscript{159} including sexual and reproductive health rights. In most cases they apply what Bandewar and others have referred to as a ‘clandestine approach’ to safeguard their sex work secrets.\textsuperscript{160} They suggest that sex workers use this approach to shield their families, more so their children, from stigmatisation as well as

\begin{itemize}
\item \textsuperscript{155} Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
\item \textsuperscript{156} Ibid.
\item \textsuperscript{157} WCW Wong, E Holroyd and A Blingham, ‘Stigma and Sex Work from the Perspective of Female Sex Workers in Hong Kong’ (2011) 33 Sociology of Health and Illness 50-65.
\item \textsuperscript{158} VA Leary, ‘The Right to Health in International Human Rights Law’ (1994) 1:1 Health and Human Rights 24, 38.
\item \textsuperscript{159} C Mgbako and LA Smith ‘Sex Work and Human Rights in Africa’ (2010) 33 Fordham International Law Journal 1178, 1180.
\end{itemize}
embarrassment.\textsuperscript{161} A human rights-based approach creates an enabling environment to deal with human rights challenges. It requires the Kenyan government to provide equal and non-discriminatory sexual and reproductive health services, as stipulated in chapter two. Sex workers are stigmatised and discriminated against even in health facilities. The healthcare providers judge them. Sex workers refer these providers as ‘hostile healthcare providers’ and they can easily identify them.\textsuperscript{162} I would refer to them as ‘blockers of quality health’. The fear of being judged damages the relationship between these two groups; the healthcare providers and sex workers. The elements of mistrust develops. While stigma is associated with public health facilities, NGO based clinics are more associated with humane treatment even when they do not always have medication as they rely on donor funds.\textsuperscript{163} They listen.

\textit{I do not go to the government [hospital] because in the first place they handle us badly. First thing if you go there with STIs, they will ask [loudly], ‘where have you gotten these prostitute diseases from?’ In the first place if a person talks to you like that you will fear to open your heart and tell them all the problems you have or what you are undergoing...}\textsuperscript{164} But many at times we do not go to those ones of the government because they abuse us and they harass us very much ... So now there are our own hospitals [NGO clinics]. Like now Bar Hostess have its own clinic. SWOP has a clinic. So you go to those clinics where you will not be asked questions. You are known as a member and you have a card. So when you go there you won’t be asked questions about who you are... You will just say I met with a client ... and we did it without a condom.\textsuperscript{165}

Alicia Yamin cautions focusing on individual health practitioners’ conduct, divorced from context which she argues, ‘frequently makes little headway and gives a human rights-approach a bad name.’\textsuperscript{166} But, Yamin contends, it should not be an excuse to condone negligence and abuse or malfeasance due to the individual actions of healthcare providers.\textsuperscript{167} In a rights-based framework, there are, argues Leslie London, three ways in which responsibility falling on health professionals may be construed.\textsuperscript{168}

\begin{footnotes}
\item[161] Ibid.
\item[162] Interview with Representative 2 of Family Health Options Kenya (Nairobi, 23 June 2015).
\item[164] Interview with Sex Worker 2 (Nairobi, 15 July 2015).
\item[165] Interview with Sex Worker 3 (Nairobi, 15 July 2015).
\item[167] Ibid.
\end{footnotes}
First, according to London, if employed by the government, a health professional may become the instrument through which the government violates the right to health and should therefore guard against involvement in such violations. Second, certain human rights obligations may have horizontal applicability among individuals, e.g. the obligation not to discriminate against other people. Lastly, human rights may be viewed as an essential part of one’s professional conduct. London argues that while the first two carry a possibility of legal sanctions, she notes that professional conduct basically rests almost entirely on professional self-regulation and ethical compliance.

It is important to understand how complaints against health professionals are dealt with especially in Kenya. When I asked how the complaints were handled, the policy maker told me that the Ministry of Health received reports against individual health professionals and ‘a lot of those complaints are directed to specific regulatory bodies - the Kenya Medical Practitioners and Dentist Board or the Nursing Council or the Clinical Officers Council.’ In addition the policy maker stated that:

*We now take that [complaints] as feedback and try to tailor our training including behavioural change and communication strategy that target care givers ... [on] things like post abortion care and sexual and gender based violence [and] just to address how to interact with patients. We try to instil dignified care in caregivers.*

In a human rights-based approach, privacy and confidentiality in the enjoyment of sexual and reproductive health rights is crucial. Nevertheless, the experience of sex workers in terms of protection of their sexual and reproductive healthcare information is different. Healthcare providers often ignore these women while sex workers want to be assured of their privacy considering the stigma and discrimination they experience. For example, a sex worker would explain her health-related issue to the healthcare provider and the provider would then call a colleague to ‘advertise’ the sex worker’s problem. The providers call them names. In fact, participants in the focus group said that in some public health facilities patients are called out loudly in terms of their diseases which raises concerns in regard to health ethics as well. With this kind of shaming attitude from people with responsibility to provide dignified care ‘…you will get up without

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169 Ibid.
170 Ibid.
171 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 July 2015).
172 Ibid.
treatment and go home. Expressing their concern with the female health providers
sex workers remarked, ‘I never understand if the women in those hospitals were born
together. They usually have the same attitude.’

They [healthcare providers] classify you. People with ‘kaswende’ (sexually
transmitted infections) this side and ringworms that side. Even if it is you with that
‘kaswende’, will you get up and go to that side? ... and yet that is the person who is
supposed to examine you and know if you have STI.

While sex workers in the study noted that private clinics were helpful, they however,
reiterated that they could not afford their health services because they are expensive.
Nevertheless, the clinics run by NGOs are different – they are friendlier to sex workers.
When they are sexually assaulted or in need of contraception, sex workers prefer to seek
help from NGO clinics because they are treated over there like human beings unlike in
the public health facilities.

Me as a sex worker, I can’t go to government clinics. I will have to go to a [private]
hospital, I feel it’s friendly. If I go to a place that is private, it is costly but they will
treat me ... or I’ll go to these clinics that NGOs have started for us. They are free.
They are so much friendlier and they understand us. They are there for us, us as sex
workers.

Sex workers’ clinics help. They help because when I come here [referring to the
BHESP office] everyone knows that I am a prostitute; even if I carry a condom or this
whole box [pointing at a condom box], they will not be surprised. [But] when I go to
a health centre [at the City Council] and I want even ten condoms they call each
other and say this one has taken lots of condoms, looks like she is fucked all the time
[laughter] ... She is a prostitute.

As a provider of sexual and reproductive health services, FHOK representative
explained ‘they come here because they have found some accommodating health care
providers.’ They have created a rapport meaning

... they can say anything to the healthcare provider attending to them without being
judged. They go to specific doctors who may not have necessarily been trained but
they have embraced sex workers and other key populations. When the particular
doctor is not there, they will not go for treatment. Some doctors are taking the

173 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
174 Ibid.
175 Ibid.
176 Interview with Sex Worker 2 (Nairobi, 15 July 2015).
177 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
178 Interview with Representative 2 of Family Health Options Kenya (Nairobi, 23 June 2015).
initiative to mentor other doctors to understand the health needs of key populations.\textsuperscript{179}

In the community, the situation is not different either. Sex workers are socially excluded. They hide to do sex work. They hide from their neighbours. They leave their houses at night for fear of being seen and operate like ‘thieves’. This makes them question if they have any rights. Churches frown upon them and so are the women in the women groups who are indifferent towards them. Similarly, the children of sex workers are mocked by the neighbours or the neighbours’ children, or at school including teachers, once information about their sex-worker mothers gets there.

... You are like an outcast in the community. It is not a job you should be heard to be doing ... even church, you are not supposed to go. There are these merry-go-round groups of women ... [over there] they say, this one is a prostitute. If my child is at school, once the teacher knows that this is the work I do, my child will be stigmatised even in school ...\textsuperscript{180}

In fact sex workers are really hated. For me when I quarrel with someone they start to tell me that ‘look at the old prostitute, all those years she has sold herself how has it helped her?’ And the way I see many prostitutes have helped themselves and they have left Korogocho ... So it means for me I don’t walk around with many women ... probably just one woman that I go with to work.\textsuperscript{181}

My children just know I am a prostitute. They hear how I’m insulted. Someone will go and tell [my child] ‘go away ... you will be a prostitute like your mother’. [My child] will come and tell me. I just tell her to let [the person] alone or to say that prostitution is a job too because you can’t lack something to eat and drink.\textsuperscript{182}

BHESP’s representative observed that continuous engagement with the community could reduce stigma. Stigma impacts on sex workers in several ways. Some brush it off and move on, while others do not. In the focus group they said it makes ‘you feel ashamed’ and also that ‘you see yourself as useless’ and ‘not worthy’. But the training sessions, as explained above, such as those conducted by NGOs who participated in this study, have given sex workers confidence to hold their heads high as evidenced by this sex worker ‘Bar Hostess has sensitised sex workers in the community and everywhere. Nowadays even if someone calls you a prostitute, you do not care because you know what you are doing.’ Before they were trained they said ‘it was hard because we had not

\textsuperscript{179} Ibid.
\textsuperscript{180} Ibid.
\textsuperscript{181} Interview with Sex Worker 1 (Nairobi, 15 July 2015).
\textsuperscript{182} Interview with Sex Worker 1 (Nairobi, 15 July 2015).
received training.’ Indicating their collectiveness as sex workers they added ‘nowadays the way we are together you do not see it [sex work] as a big thing’.

The discrimination that exists in the provision of sexual and reproductive health services is associated with individual perceptions, attitudes, values and moral standpoints in society. Explaining why sex workers preferred NGO provided services to government facilities when accessing their sexual and reproductive health services, FHOK said that ‘for us we go a stretch … to want to know who you are and knowing who you are informs the quality of services and also ensures that we address future possible problems appropriately.’ NGO-based clinics focus on trust with sex workers and this is not the same with public health facilities. While the public health facilities have very limited time for client-patient relationships, they are also said to have no follow-ups beyond the hospital setting. When I asked what could be done in terms of the healthcare providers attitudes, FHOK representative stressed ‘… value clarifications is one of the strategies to change the attitude at whatever level … until we get clarification in our values, there is no way we are going to change our attitudes … It should start with healthcare providers … and the society … including magistrates and lawyers.’ Giving her own personal experience she commented ‘five years ago the way I knew about key population and the way I perceived them is completely different because my [values] have been clarified from time to time … until now … I am able to see yeah, it is their right …’ These attitudes could even be more challenging for key populations with disability such as visually impaired sex workers as revealed during my fieldwork. This area merits further empirical investigation to distil the lived experiences of sex workers living with disability in the global south.

Where necessary, sex workers should be referred to other health facilities for sexual and reproductive health services particularly ‘if they cannot provide those services for one or many other reasons then they need to give you a referral to a facility that can provide you with these services.’ But there are differences in how referrals from government health facility and for example FHOK clinic are conducted. In a

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183 Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
184 Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
185 Ibid.
186 Ibid.
187 Ibid.
188 Ibid.
189 Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 July 2015).
government facility a person has to revisit their medical history with a doctor and also gets discouraged because of the long queues, coupled with the negative attitudes and discrimination from service providers, so she shies away.\textsuperscript{190} FHOK, on the other hand, has organised a referral system with other health institutions and gives the person being referred a referral coupon which helps the health provider to link with the type of service the person has come for.\textsuperscript{191} They refer their clients, including sex workers, for legal services if need be, for example in a case of rape or other abuse. The Kenyan government approves health institutions that can fill in a ‘P3 Form’ for court purposes. One of the limitations of FHOK, however, is that it does not have the authority to issue a Kenya Police Medical Examination form (known as ‘Police Form 3’ or ‘P3 Form’)\textsuperscript{192} meaning that the organisation has to refer people mostly women, for these services. As much as FHOK and other organisations may have won the trust of sex workers and other key populations with their provision of the much friendlier sexual and reproductive health services, their doctors cannot give medical evidence in court. This limitation, in essence, tampers with FHOK’s ability to help realise sexual and reproductive health and rights.

6.3 Conclusion

The chapter has presented an original piece of empirical research conducted through in-depth interviews and a focus-group discussion with sex workers, health professionals, the police, policymakers and NGOs in Kenya. It has presented the findings in two broad themes supported by subthemes to understand the Kenyan context in terms of the enjoyment of sexual and reproductive health rights by women, especially sex workers. In presenting these findings, the chapter has provided the focus of the Kenyan government, particularly given its express recognition of a rights-based approach to ensure sexual and reproductive health rights for all Kenyans, including sex workers. The findings show that the Constitution of Kenya 2010 has presented sex workers with a space to champion their sexual and reproductive health rights, as well as to demand inclusion and accountability from the government, and to challenge discriminatory treatment targeting sex workers. When laws are confusing, misinterpreted, contradictory

\textsuperscript{190} Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
\textsuperscript{191} Ibid.
and ambiguous, sex workers in much of the global south fail to understand the correct position of the law\textsuperscript{193} which exposes them to numerous human rights violations. My final chapter concludes and suggests strategic ways in which the use of a rights-based approach should benefit sex workers as a strategic argument to hold the government of Kenya accountable and that, rights-based laws and policies can be meaningfully utilised to alleviate inequalities and discriminatory practices for women, especially sex workers, regarding their enjoyment of sexual and reproductive health rights in Kenya.

\textsuperscript{193} Overs, \textit{Sex Workers, Empowerment and Poverty Alleviation in Ethiopia} (n 107).
Chapter Seven

Conclusion and Recommendations

7.0 Introduction

International human rights law is part of Kenyan law. In chapter three, section 3.3 this thesis has shown that the Constitution of Kenya 2010 has provided the framework within which to enforce the rights to the highest attainable standards of health including sexual and reproductive health for women. The thesis argued in chapter two, section 2.1, that despite criticisms, a human right-based approach grounded in international human rights law, is necessary. The central question of the thesis was whether the adoption of a human rights-based approach could guarantee the sexual and reproductive health of sex workers in Kenya. The thesis explored four further supporting questions that helped to answer this question: (a) To what extent have laws and policies adopted a rights-based approach? and (b) What are the mechanisms that promote or deny the enjoyment of sexual and reproductive health rights of sex workers? The two questions critically examined international and national legal frameworks anchoring human rights entitlements within a framework of laws, declarations and consensus documents and both of whom have been answered in chapters three and five in sections 3.1, 3.2, 3.3, 5.1.5, 5.2.1, 5.2.2 and 5.2.3. In particular, sections 5.1.1, 5.1.2, 5.1.3 and 5.3 have addressed the hurdles to sexual and reproductive health rights.

As to (c) What are sexual and reproductive health rights? and (d) In what ways can sex workers realise their sexual and reproductive health rights?, these questions have primarily been answered in chapter six. The chapter provided original empirical research data obtained in fieldwork and amplified the voices of sex workers on their lived experiences with the laws and policies on the ground. It provided the understanding of sexual and reproductive health rights and illuminated the opportunities to enjoy the right to sexual and reproductive health in sections 6.2.1.1, 6.2.1.2, 6.2.1.3, 6.2.1.4 as well as 6.2.2.1, 6.2.2.3 and 6.2.2.5 of the study. The findings from the fieldwork clearly support the contention that women would benefit from a human rights-based approach.
Reflecting on the thesis, this chapter provides conclusions and suggest strategic ways in which rights-based laws and policies can be meaningfully utilised to alleviate inequalities and discriminatory practices to enable sex workers to enjoy their sexual and reproductive health rights. It presents (in section 7.1) the ways in which the research has made an original contribution to the body of research and provides recommendations (in section 7.2).

7.1 Contribution to Research

The study has contributed to the body of research on the sexual and reproductive health rights of women and other marginalised groups in Africa and in the global south. It has done so in the following ways:

Original Piece of Empirical Research

The thesis constitutes an original piece of empirical research, based on fieldwork in Kenya, focusing on sex workers, non-governmental organisations (NGOs), government officials, health professionals and the police. It adds exceptional value, because it has contributed to investigating the relatively young human rights culture in Kenya and how marginalised groups are treated in this new and challenging environment.¹ The in-depth interviews and the focus-group discussion in this thesis helped determine the focus needed by the Kenyan government with respect to the struggle of women to enjoy their sexual and reproductive health rights. They reveal how international, regional and national laws and policies are actually implemented in practice. The findings in chapter six sections 6.2.1 and 6.2.2 show that there are opportunities that facilitate the enjoyment of sexual and reproductive health rights and factors that hinder their enjoyment in Kenya.

The findings suggest in chapter six, section 6.2.1.2 that although the understanding of human rights is generally weak in Kenya; particularly in the public sector, but also

throughout the wider population, the Constitution of Kenya (2010) is a powerful catalyst for change. Sex workers in section 6.2.1.1 are coming out, identifying themselves as sex workers and articulating their own sexual and reproductive health in terms of rights e.g. their right to use family planning, the right to protection to avoid pregnancy and the right to safe sex to be protected from HIV and sexually transmitted infections and to anti-retroviral therapy treatment after unsafe sex especially with aggressive clients. The Constitution does not directly mention sex workers, however it puts a strong emphasis on the rights of vulnerable and marginalised groups as studies have shown.²

What was found in section 6.2.1.3 is a key human rights-based approach principle; that sex workers in Kenya now demand to be involved, engaged and consulted on matters that concern them including on policy issues on sexual and reproductive health rights. They are working in solidarity as a ‘community’ and not only with each other locally but also on an international level with organisations such as African Sex Workers Alliance in Africa and the Global Network of Sex Work Project to fight for their rights. As one participant confirmed ‘we believe working in groups makes people stronger than working with one person. In a group you can have a voice, but one voice is never heard.’³ A further finding revealed that sex workers were empowered by NGOs through capacity building as well training peer-to-peer educators and paralegal sex workers. The training has played a key role in instilling confidence in sex workers to advocate and articulate their sexual and reproductive health rights according to section 6.2.1.4 and transformed the silence of sex workers into language and action.⁴ In Mlolongo, for example, sex workers would not agree to sex without the use of condoms. Empowerment as discussed in chapter two section 2.1.1 is an important principle of a human rights-based approach. Studies have shown that international, regional and national laws and policies can make a difference if women are empowered to use their rights and know what to do if their rights are violated.⁵

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³ Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
⁵ RJ Cook, ‘Enforcing Women’s Rights through Law’ (1995) 3:2 Gender and Development 8,
There are barriers and obstacles that have severe impacts on the lives of sex workers as shown in section 6.2. Even with the current constitutional framework, section 6.2.2.2 reveals that laws and policies are ambiguous, confusing and often misinterpreted e.g. on abortion and sex work and the government’s sexual and reproductive health policies are not effective. They are passed and shelved and are not followed or enacted. Some sex workers in Kenya and in other countries, such as the sex workers study in Ethiopia, do not know the correct legal status of sex work as presented in section 6.2.2.3. In the focus group some sex workers thought that it was the money they are paid that makes the police jealous of their income and arrest them. Sex workers are not only treated as criminals, the research findings further show that the police use them as their ‘crime control-strategy’ and they are seen as ‘useful’ informers of the whereabouts of alleged criminals. I have argued in the same section that care should be taken with such views as they do not serve the interest of sex workers and suggest instead that sex workers are linked to criminals. This has its implications; it makes women in sex work susceptible to further abuse. The lack of clarity of laws and policies that affect sex workers serves to instil fear, anxiety and uncertainty in their lives especially in their sexual and reproductive health lives.

Confirming police arrest and harassment of sex workers including coerced sexual services in other studies, this study specifically shows in section 6.2.2.4, the empowerment of sex workers to enable the law to be challenged. An example of this is unlike before the 2010 Constitution was enacted they do not plead guilty when they are arraigned in court and that they now understand that the police have the responsibility to prove the case against them beyond reasonable doubt. Sex workers are vulnerable to violence as other studies and section 6.2.2.5 has shown. I have argued in section 3.2.1.2 that even when international human rights law outlaws gender-based violence followed by the Kenyan criminal sanctions, the lack of action provides an enabling environment for abuse against women particularly sex workers to thrive. After agreeing to go with a client they are beaten, coerced into sex, gang raped and subjected to sex

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7 C Overs, Sex Workers, Empowerment and Poverty Alleviation in Ethiopia (Institute of Development Studies 2014) 18.
with dogs and to sex without condoms by some clients and this has profound effect on their sexual and reproductive health. The study reveals that sex workers are employing their own safety measures to help improve their security such as choosing the place to sleep with clients and informing fellow sex workers of their whereabouts as they continue to fight for their rights. Equally, and in solidarity with other sex workers community in Africa and around the globe, they use the International Sex Worker Rights Day and International Day to End Violence against Sex Workers platform to call for attention on this violence including punishment of offenders and for sex workers to be treated with dignity as humans as shown in section 6.2.1.3.

Non-discrimination and equality are fundamental principles for women to enjoy their sexual and reproductive health rights as argued in sections 2.1.1 and 3.2.1.1. The findings in section 6.2.2.6 show that sex workers experience deep societal stigma and discrimination. This affects their ability to advocate for their own human rights\(^\text{10}\) and for some this means they choose to work clandestinely like ‘thieves’. In the community (i.e. neighbours, church as well in women groups) they are treated with prejudice and this extends to providers especially in public health facilities. Instead sex workers prefer to use NGO provided sexual and reproductive health services which they find far friendlier. These attitudes could even be more challenging for key populations with disability e.g. a visually impaired sex worker in accessing sexual and reproductive health and this area merits further empirical investigation to distil the lived experiences of sex workers living with disability in the global south.

The underfunded health sector and other obstacles in section 6.2.2.1 reveal a systematic lack of attention by the government to ensure that sexual and reproductive health goods, services and facilities are available, accessible, acceptable and of good quality for women. These are key elements for the realisation of right to the highest attainable standard of health including sexual and reproductive health important in a human rights-based approach as highlighted in section 2.1.2.

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**The Timeliness of the study vis-à-vis the Constitution**

As discussed in chapter one, the old Kenyan Constitution\(^{11}\) was described as ‘a major bottleneck’ in the realisation of women’s human rights.\(^{12}\) Yet, the Constitution of Kenya 2010 promulgated in August 2010 has been described as ‘the most important political development in Kenya since its independence in 1963’, ‘one of the most progressive constitutions in Africa’\(^{13}\) and a ‘human rights-based Constitution’.\(^{14}\)

Women’s rights are constitutionalised and indeed for the first time since independence it embodies several specific gains the Kenyan women struggled for including elimination of gender discrimination in relation to issues on land, marriage as well as citizenship. It remains therefore that it is not enough to have these rights in the supreme law of the land but that the Kenyan government has to show its commitment to implement women’s rights without any form of discrimination. The thesis has shown that the fundamental provisions in Article 2(5) and (6) of the 2010 Constitution making international law part of the Kenyan law obligates the government of Kenya to uphold international human rights principles and standards.

The thesis has provided an analysis of Kenya’s human rights culture and the potential of the 2010 Constitution to address the Kenyan sex workers’ enjoyment of sexual and reproductive health rights. Kenya has ratified many international and regional human rights instruments as shown in section 1.0 and it is obligated to respect, protect and fulfil women’s sexual and reproductive health rights. Therefore the Kenyan government must address barriers to the enjoyment of sexual and reproductive health rights in the country. Lack of it must be challenged. I have argued in sections 3.2 and 3.3 that the international and regional human rights treaties (CEDAW, ICESCR and Maputo Protocol including treaty bodies) and the Kenyan Constitution provide a legal framework within which to address inequality and discrimination of women in Kenya. This framework also addresses access to information and gender-based violence both of


which have a significant impact on the enjoyment of sexual and reproductive health rights of women and sex workers in particular.

As argued in chapter five section 5.1.1 the criminal status of sex work in Kenya, has been used to legitimise the mistreatment of sex workers and to support an apparent widespread acceptance among the general public that such conduct towards these women is justifiable.\textsuperscript{15}

Inasmuch as prostitution is commonly understood to be illegal, the law in Kenya does not define prostitution; neither does it criminalise it per se.\textsuperscript{16} The provisions of both the Penal Code and the Sexual Offences Act (2006) do not criminalise the practice of sex work in and of itself,\textsuperscript{17} though human rights violations, including in relation to sexual and reproductive health rights, continue to occur, despite Kenya’s comprehensive and ‘rights-based’ Constitution. It is also argued in the same section that criminalisation impacts on the sexual and reproductive health rights of sex workers and other vulnerable and marginalised groups. For example, sex workers continue to be murdered in different parts of the country, which violates the very principles of human rights which are guaranteed in international human rights treaties where Kenya is a party. An example of this is right to life.\textsuperscript{18} Many of these cases are not properly investigated and/or successfully prosecuted for lack of evidence, influenced by the discrimination and the environment in which sex workers operate.\textsuperscript{19} Section 3.2.1.3 has argued that


\textsuperscript{17} Ibdi 9.


\textsuperscript{19} Kenya Sex Worker Alliance (KESWA) and Bar Hostess Empowerment and Support Program (BHESP), Kenya Sex Workers’ Shadow Report Submission to the United Nations Committee on the Elimination of Discrimination against Women 68th Session (KESWA and BHESP 2017) 9-10.
CEDAW’s failure to define the term ‘exploitation of prostitution’\textsuperscript{20} has left different jurisdictions to interpret it differently, which has justified the punishment of sex workers.\textsuperscript{21}

Section 5.1.4 has shown that sex work law is a hot debate in many parts of the world, including in Kenya, and that the debate on criminalisation of purchase of sexual services is spreading around the globe. However, it has argued that the voices of sex workers in the Kenyan context is critical and should be heard and listened to. It is argued that in an environment where sex workers are murdered and few if any prosecutions are conducted, criminalisation of the purchase of sexual services in the Kenyan context would expose sex workers to further human rights violations and is incompatible with human rights-based approach. Decriminalisation has been associated with the promotion of health, including sexual and reproductive health rights and the human rights of sex workers in general, and it is argued in the same section that Kenya should decriminalise sex work.\textsuperscript{22}

Abortion in Kenya is permitted under certain circumstances, according to Article 26(4) of the Constitution of Kenya, but this thesis in section 5.1.2 and section 6.2.2.2 has added to the understanding of availability of abortion services where it has shown that contradictory abortion law exacerbates the lack of accurate information thus hinders women and more so sex workers’ access to safe abortion services.\textsuperscript{23} Women and health professionals are threatened with prosecution under the Kenyan Penal Code. Given the circumstances under which unsafe abortions are conducted, the thesis has argued that like most women, sex workers will only go to a hospital for help when it is too late, for fear of prosecution, and thus they are faced with several risks to their sexual and reproductive health rights, including the loss of their lives. The thesis has equally argued in section 5.1.2 that it is in this criminal environment that unsafe abortion numbers continue to escalate in Kenya and other countries that have punitive colonial abortion laws, which is incompatible with a human rights-based approach.

\textsuperscript{21} C Overs and B Loff, ‘Toward a Legal Framework that Promotes and Protects Sex Workers’ Health and Human Rights’ (2013) 15:1 Health and Human Rights 186,
\textsuperscript{22} See Amnesty International, ‘Policy on State Obligations to Respect, Protect and Fulfil the Human Rights of Sex Workers’ (Amnesty International 2016)
\textsuperscript{23} Constitution of Kenya 2010, Article 26(4).
The research has investigated in chapter five different policies on sexual and reproductive health, including, importantly, the Health Act (2017), the first Kenyan health law under the new constitutional order which implements Article 43 of the Constitution of Kenya (2010) on the right to the highest attainable standard of health including sexual and reproductive health care. The Kenyan new health law as shown in section 5.1.5 sets out three primary responsibilities of the Kenyan government under international human rights law: to respect, protect and fulfil the right to health. The Health Act (2017) expressly guarantees the right to the highest attainable standards of health for every individual, including sex workers, in Kenya; and it obligates the Kenyan government to ensure that the constitutional right to health, including reproductive healthcare and emergency medical treatment, is observed, respected, promoted and fulfilled.

The Kenyan Health Act (2017) mentions ‘women’ six times, ‘right’ 34 times and ‘duty’ seven times. It defines 37 terms, including health, abortion and informed consent. The health law defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, abortion as the ‘termination of a pregnancy before the foetus is viable as an independent life outside the womb’ and informed consent as ‘a process of getting permission before conducting a health care prevention on a person’. Section 12 permits healthcare providers to ‘refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her except in an emergency situation where no alternative health care personnel is available’. The thesis has argued in the same section 5.1.5 that the Act fails to define ‘physically abusive’ or ‘verbally abusive’ users, yet this provision may be open to misinterpretation, especially in a health sector where sex workers already face stigmatised and discriminatory treatment. In implementing the new health law in Kenya,

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25 Health Act 2017, Section 5(1).
26 Ibid Section 4.
27 Ibid Section 2.
28 Ibid.
29 Ibid.
30 Ibid.
31 Ibid Section 12(c).
I have argued that the government should be reminded that under a rights-based approach rarely is just one right violated and that the enforcement of the right to sexual and reproductive health also involves a right to information, a right to life, a right to dignity, a right to privacy, a right to education and a right to non-discrimination as pointed out in chapter one section 1.0.

I have shown, in chapter two section 2.0 and chapter five, sections 5.1.5 and 5.2.1 that the government has explicitly said in its policies, e.g. in its Health Policy 2012–2030 and the National Reproductive Health Policy (2007), that a human rights approach has a significant role to play in delivering the right to the highest attainable standards of health, including sexual and reproductive health in Kenya; equally, it was confirmed by the policymaker that ‘...in terms of targeting the policies, we are really stressing a rights-based approach' and further confirmed that the government has adopted a rights-based approach in its gender programme that ensures women, and especially vulnerable and marginalised groups such as sex workers, have equal access to non-discriminatory sexual and reproductive health rights. Despite this explicit position of the government, the study finds section 6.2.1.1 that in practice, the government is threatened by a human rights approach.

The advocates of a rights-based approach risk a backlash from the government, yet it is in this environment that the sexual and reproductive health rights of women and sex workers are compromised. A human rights-based approach requires that adherence to human rights standards leads not only in the development of sexual and reproductive health policy, but also in implementation as well as monitoring.

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34 Interview with the Representative of the Division of Reproductive Health (Ministry of Health, Nairobi, 24 June 2015).
35 Ibid.
36 Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
principles and standards that it claims to uphold, which require that Kenyan laws and policies on sexual and reproductive health rights should be based on participation and inclusion, accountability and transparency, non-discrimination and equality, empowerment and the rule of law, as discussed in chapter two.

**Transnational Feminist Theory**

I have used transnational feminist theory to build on postcolonial feminist theory in chapter two, section 2.3 and chapter five to not only draw attention of the gap between laws and policies and the reality on the ground but to expose injustices against sex workers and how they are tolerated in Kenya as in other African countries and to further argue that a rights-based approach can help address the sexual and reproductive health rights-related injustices against sex workers. Also that the ‘objectification’ and ‘victimisation’ of sex workers in Kenya invalidate their voices and deny them the agency and self-determination to make their own sexual and reproductive health decisions.

I have explored the local and global dimensions of the struggles of sex workers, particularly when domestic laws that impact on their sexual and reproductive health rights are increasingly influenced by regional and international human rights principles, as shown in chapter three and five of the thesis including court decisions.

Defining myself as a ‘woman cracked by multiple migrations’, I have provided in the thesis my position as a researcher defining my privilege and aware of the impact this has on my research.

### 7.2 Recommendations

Although the findings of this research elicit many suggestions that are incorporated into the thesis, here there are three strategic ways in which rights-based laws and policies

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can be meaningfully utilised to alleviate inequalities and discriminatory practices for sex workers to enjoy their sexual and reproductive health rights:

First, implement and reform the law: The 2010 Constitution needs to be implemented, upheld and challenged where necessary. The devolved health responsibilities now at County level need to be monitored and future research to document both violation and progress made in the realisation of sexual and reproductive health rights of women, especially sex workers including sex workers with disability and marginalised groups in different counties is undertaken.

In regard to existing laws there needs to be clarification and implementation alongside their dissemination. Health laws and policies including on sexual and reproductive health e.g. on abortion and including sex work are ambiguous, confusing, misinterpreted and have not been disseminated (shown in section 6.2.2.2). Clear and dissemination of laws will empower women to hold the government accountable to its national and international human rights obligations.\footnote{AE Yamin and R Cantor, ‘Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health’ (2014) 6:3 Journal of Human Rights Practice 451, 458 and 459.}

Decriminalise sex work. Sex workers in Kenya are at risk of violence and abuse irrespective of the new Constitution of Kenya as evidence in this study has shown in section 6.2.2. Criminalisation of the purchase of or the criminalisation of demand for sexual services in section 5.1.4 is associated with exposing sex workers to further human rights violations while decriminalisation promotes sex workers right to health and respect for their human rights for example, in New Zealand.

Enact new legislation covering equality and discrimination to protect women, especially sex workers, from discriminatory sexual and reproductive health services and give effect to Article 27 of the Constitution on discrimination in section 3.3.1, Article 1 of the CEDAW in section 3.2.1.1 and Article 2 of the Maputo Protocol in section 3.2.2 of the thesis.

Second, training: Training with the different stakeholders and interest groups, i.e. health care providers, police, judicial officers, lawyers and government departments on a human rights-based approach to health, including sexual and reproductive health, for it has the potential to improve development and implementation of policy for vulnerable
or marginalised groups such as sex workers. In so doing, they will be brought together
to share health including sexual and reproductive health-related knowledge and
experienced injustices to catalyse HRBA health policy reforms to avert health injustices
shown in chapters five and six.\textsuperscript{43} Additionally, training should focus on collecting
evidence on the impact of HRBAs in the country.\textsuperscript{44}

Third, support sex worker networking: There needs to be enhancement and further
facilitation of networking. In Kenya, sex workers as seen in section 6.2.1.3 are
collaborating at the local, national, regional and international levels with other sex
workers across the globe including presenting shadow reports as shown in chapter three.
The support for this networking should be encouraged to share their struggles and for
their voices to be heard and, for their greater empowerment. Where relevant, it will also
allow the theoretical debate to take account of the needs of sex workers both in Kenya
and in other countries in Africa. In their Shadow reports to the Committee on the
Economic, Social and Cultural Rights and the African Commission on Human and
Peoples’ Rights, sex workers and other marginalised groups should make calls upon the
CESCR Committee to encourage Kenya to remove the reservation under Article 10(2)
of ICESCR and Articles 10(3) and 14(2)(c) of the Maputo Protocol addressed in section
3.2.3 while showing how these reservations impact the realisation of women’s right to
sexual and reproductive health in Kenya. In addition, relentlessly lobby the Kenyan
government to review and remove these reservations to conform to the 2010
constitutional promises.

Among these suggestions it is perhaps over ambitious to suggest that Kenya will
decriminalise sex work in the current socio-political environment, especially as there
are many human rights issues that Kenyan citizens experience. That this thesis is bold
enough to suggest and provide the evidence for such a step is meant to aid the debate to
move to a point where sex worker’s rights are valued and upheld. This research has
provided an analysis indicating future directions useful to non-governmental
organisations, including donors, to know how best to lobby for the decriminalisation of
sex work and to hold the Kenyan government accountable to its international, regional
and national commitments.

\textsuperscript{43} Ibid.
\textsuperscript{44} F. Songane, ‘Interview with Francisco Songane: Evidence of Impact of Human Rights-Based
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**International and Regional Human Rights Treaties**


Charter of the United Nations signed on 26 June 1945 and came into force on 24 October 1945.
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), GA Res 39/46 (1984).


**General Comments**

African Commission on Human and Peoples’ Rights, General Comment No. 2 on Article 14(1)(a), (b), (c) and (f) and Article 14 (2)(a) and (c) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (adopted at 55th Ordinary Session, 28 April to 12 May 2014, Luanda, Angola).
African Commission on Human and Peoples’ Rights, General Comments on Article 14 (1)(d) and (e) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (adopted at 52nd Ordinary Session, 9 to 22 October 2012, Yamoussoukro, Côte d’Ivoire).


**Concluding Observations and Sate Reports**


Committee on Economic, Social and Cultural Rights, Concluding Observations: Kenya

Committee on Economic, Social and Cultural Rights, Concluding observations: Kenya

Committee on the Elimination of Discrimination against Women, Eighth Periodic

Committee on Economic, Social and Cultural Rights, Concluding Observations: Kenya
UN Doc E/C.12/KEN/CO/2-5.

United Nations and African Union Documents
African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases

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National Adolescent Sexual and Reproductive Health Policy 2015 (Kenya).
National Reproductive Health Policy 2007 (Kenya).
Preservation of Human Dignity and Enforcement of Economic and Social Rights Bill
2015 (Kenya).
Prohibition of Female Genital Mutilation Act No 32 of 2011 (Kenya).
Protection against Domestic Violence Act No 2 of 2015 (Kenya).
Reproductive Health Care Bill 2014 (Kenya).
Sexual Offences Act No 3 of 2006 (Kenya).
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Statute Law (Miscellaneous Amendments) Act of 2012 (Kenya).
Treaty Making and Ratification Act No 45 of 2012 (Kenya).
## Appendix A: Selected International and Regional Treaties Ratified by Kenya

<table>
<thead>
<tr>
<th>International Treaties</th>
<th>Ratification</th>
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<tbody>
<tr>
<td>International Covenant on Economic, Social and Cultural Rights</td>
<td>1 May 1972</td>
</tr>
<tr>
<td>Optional Protocol to the International Covenant on Economic, Social and Cultural Rights</td>
<td>Not ratified</td>
</tr>
<tr>
<td>International Covenant on Civil and Political Rights</td>
<td>1 May 1972</td>
</tr>
<tr>
<td>Optional Protocol to the International Covenant on Civil and Political Rights</td>
<td>Not Signed</td>
</tr>
<tr>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
<td>9 March 1984</td>
</tr>
<tr>
<td>Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children</td>
<td>5 January 2005</td>
</tr>
<tr>
<td>Optional Protocol to the Convention on the Elimination of Discrimination against Women</td>
<td>Not signed</td>
</tr>
<tr>
<td>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
<td>21 February 1997</td>
</tr>
<tr>
<td>Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others</td>
<td>Not signed</td>
</tr>
<tr>
<td>Convention on the Rights of the Child</td>
<td>30 July 1990</td>
</tr>
<tr>
<td>Rome Statute of the International Criminal Court</td>
<td>15 March 2005</td>
</tr>
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### Regional Treaties

<table>
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<tr>
<th>Regional Treaties</th>
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<tbody>
<tr>
<td>Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa</td>
<td>8 October 2010</td>
</tr>
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Appendix B: Ethics Approval Certificate

University of Sussex

Certificate of Approval

Reference Number: ER/ML366/1
Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach
Principal Investigator (PI): MaryFrances Lukera
Student: MaryFrances Lukera
Collaborators: n/a
Duration of Approval: n/a
Expected Start Date: 01-Mar-2015
Date of Approval: 02-Dec-2014
Approval Expiry Date: 01-Mar-2016
Approved By: Jayne Paulin
Name of Authorised Signatory: Stephen Shute
Date: 02-Dec-2014

*NB. If the actual project start date is delayed beyond 12 months of the expected start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures.

Please note and follow the requirements for approved submissions:

Amendments to protocol
- Any changes or amendments to approved protocols must be submitted to the C-REC for authorisation prior to implementation.

Feedback regarding the status and conduct of approved projects
- Any incidents with ethical implications that occur during the implementation of the project must be reported immediately to the Chair of the C-REC.

Feedback regarding any adverse and unexpected events
- Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social Sciences C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence.
# Appendix C: Consent Form for Sex Workers

Name of the Researcher: Mary Frances A Lukera  
School of Law, Politics and Sociology, University of Sussex  
Title of the Project: Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach  
Please complete **ALL** the statements below and **CIRCLE** your choice

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I confirm that I have had the project explained to me and I have read and understood the Information Sheet, which I may keep for records.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without giving reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I have had the opportunity to ask questions and I agree to take part in the above project.</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>I agree to the interview/focus group/consultation being audio recorded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I agree if I am participating in the focus group, to respect the confidentiality of other participants.</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>I agree that my name will be anonymised in the project.</td>
<td></td>
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<tr>
<td>7</td>
<td>I agree to the use of anonymised quotes in the project.</td>
<td></td>
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<tr>
<td>8</td>
<td>I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998.</td>
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<tr>
<td>Name of participant</td>
<td>Signature</td>
<td>Date</td>
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<tbody>
<tr>
<td>Name of the Researcher</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>
**Appendix D: Consent Form for Professionals**

Name of the Researcher: MaryFrances A Lukera

School of Law, Politics and Sociology, University of Sussex

Title of the Project: Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach

Please complete **ALL** the statements below and **CIRCLE** your choice

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I confirm that I have had the project explained to me and I have read and understood the Information Sheet, which I may keep for records.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without giving reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I have had the opportunity to ask questions and I agree to take part in the above project.</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>I agree to the interview/focus group/consultation being audio recorded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I understand that I have given my approval for my name to be used in the project.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I agree to the use of anonymised quotes in the project.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998.</td>
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<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Signature</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Name of the Researcher</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Appendix E: Coded List of Interviews

Interview with Sex Worker 1 (Nairobi, 15 July 2015).
Interview with Sex Worker 10 (Nairobi, 15 July 2015).
Interview with Sex Worker 2 (Nairobi, 15 July 2015).
Interview with Sex Worker 3 (Nairobi, 15 July 2015).
Interview with Sex Worker 4 (Nairobi, 15 July 2015).
Interview with Sex Worker 5 (Nairobi, 15 July 2015).
Interview with Sex Worker 6 (Nairobi, 15 July 2015).
Interview with Sex Worker 7 (Nairobi, 15 July 2015).
Interview with Sex Worker 8 (Nairobi, 15 July 2015).
Interview with Sex Worker 9 (Nairobi, 15 July 2015).
Focus Group Discussion with Sex Workers (Nairobi, 9 July 2015).
Interview with Representative 1, Family Health Options Kenya (Nairobi, 23 June 2015).
Interview with Representative 2, Family Health Options Kenya (Nairobi, 23 June 2015).
Interview with Inspector of Police (Nairobi, 10 July 2015).
Interview with Representative, Bar Hostess Empowerment and Support Programme (Nairobi, 1 July 2015).
Interview with Representative, Division of Reproductive Health (Ministry of Health, Nairobi, 24 July 2015).
Interview with Representative, Kenya Sex Workers Alliance (Nairobi, 25 June 2015).
Interview with Representative, Highway Community Health Resource Centre (Mlolongo, 23 July 2015).
Interview with Health Professional (Nairobi, 25 June 2015).
Appendix F: Recruitment Letter for Sex Workers

Date .............................

From: MaryFrances Lukera
PhD Candidate in Law Studies
School of Law, Politics and Sociology
University of Sussex
Brighton, BN1 9RE, United Kingdom

To: .........................................................

Dear ..............................................,

Re: Request for your participation in a Research Study on Sex Workers and their Sexual and Reproductive Health and Rights

I am writing to request for your participation in the research study Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach. This study is part of my doctoral degree studies at the School of Law, Politics and Sociology, University of Sussex, United Kingdom.

Sex workers rights are human rights and Sexual and reproductive health and rights are fundamental to women’s health and development. This study recognises the enactment of the Constitution of Kenya 2010 and the fact that any treaties ratified by Kenya shall form part of the Kenyan law. The study seeks to analyse from a rights-based perspective the legal opportunities available for sex workers to realise their sexual and reproductive health and rights in Kenya. In order to achieve this, the study examines the meaning of sexual and reproductive health and rights, how the law promotes or hinders the realisation of sexual and reproductive and rights in Kenya and how sex workers can realise these rights.

Recognising the important role you play in interacting with the law on women’s sexual and reproductive health and rights in Kenya, you are kindly invited to an interview, which is aimed to gather information on your experience. The interview is voluntary and the attached Information Sheet will provide you with detailed information about this study. The interview will take about 45 minutes and if you have any further questions about the study please do not hesitate to contact me either by phone +254 724057062 or email: M.Lukera@sussex.ac.uk.

Thanking you for your time.

Yours faithfully,

MaryFrances Lukera

PhD Candidate, University of Sussex, UK
Appendix G: Recruitment Letter for Professionals

Date ………………………

From: MaryFrances Lukera
PhD Candidate in Law Studies
School of Law, Politics and Sociology
University of Sussex
Brighton, BN1 9RE, United Kingdom

To: ………………………………………………………….

Dear ……………………………………………………..,

Re: Request for your participation in a Research Study on Sex Workers and their Sexual and Reproductive Health and Rights

I am writing to request for your participation in the research study Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach. This study is part of my doctoral degree studies at the School of Law, Politics and Sociology, University of Sussex, United Kingdom.

Sex workers rights are human rights and Sexual and reproductive health and rights are fundamental to women’s health and development. This study recognises the enactment of the Constitution of Kenya 2010 and the fact that any treaties ratified by Kenya shall form part of the Kenyan law. The study seeks to analyse from a rights-based perspective the legal opportunities available for sex workers to realise their sexual and reproductive health and rights in Kenya. In order to achieve this, the study examines the meaning of sexual and reproductive health and rights, how the law promotes or hinders the realisation of sexual and reproductive and rights in Kenya and how sex workers can realise these rights.

Recognising the important role you play in advancing the law on women’s sexual and reproductive health and rights in Kenya, you are kindly invited to an interview, which is aimed to gather information on your experience. The interview is voluntary and the attached Information Sheet will provide you with detailed information about this study. The interview will take about 45 minutes and if you have any further questions about the study please do not hesitate to contact me either by phone +254 724057062 or email: M.Lukera@sussex.ac.uk.

Thanking you for your time.

Yours faithfully,

MaryFrances Lukera

PhD Candidate, University of Sussex, UK
Appendix H: Guiding Questions for Sex Workers

1. What do sexual and reproductive health and rights mean to you?

2. In your opinion are sex workers entitled to sexual and reproductive health rights?

3. Why are sexual and reproductive health rights important to sex workers?

4. What opportunities do you think are available for sex workers to realise their sexual and reproductive health rights?

5. What experience would you say you have had with the law on sexual and reproductive health rights?

6. How do sex workers advocate for their sexual and reproductive health rights?

7. What role do sex workers have, to ensure they realise their sexual and reproductive health rights?

8. What discrimination do sex workers experience if any?

9. In your experience how does the law promote or hinder realisation of sexual and reproductive health rights?

10. What other suggestions do you have?
Appendix I: Guiding Questions for Policy Makers/Non-Governmental Organisations/Health Care Professionals

1. What do you understand by sexual and reproductive health and rights?
2. Why should sexual and reproductive health rights of sex workers be addressed?
3. How does your role impact on sexual and reproductive health rights in Kenya?
4. How do the laws promote or hinder sexual and reproductive health rights?
5. What legal opportunities are available for sex workers to realise their sexual and reproductive health rights?
6. How would you describe sexual and reproductive health rights in the Kenyan context before and after the Constitution 2010?
7. What kind of abuse would you relate to sexual and reproductive health rights of sex workers and how would you propose to deal with them?
8. How does policy address stigma and discrimination of sex workers?
9. What policy change would you like to see in the area of sexual and reproductive health rights?
10. What other suggestions would you like to make?
Appendix J: Information Sheet for Sex Workers

Participant Information Sheet

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Study Title: Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach

What is the Purpose of the Study?

The purpose of this study is to interrogate how a human rights approach would guarantee sexual and reproductive health rights of sex workers in Kenya. It seeks to understand the meaning of sexual and reproductive health and rights, the current legal situation of sexual and reproductive health rights and how sex workers in Kenya can achieve these rights.

What Motivates the Researcher?

Sexual and reproductive health rights are human rights. This study recognises the enactment of the Constitution of Kenya 2010 which explicitly recognises the right to the highest attainable standard of health including reproductive health care. The Kenyan Constitution also provides for equality stipulating the Universal Declaration on Human Rights that all human beings including sex workers are born free and equal in dignity and rights. The use of human rights as framework to meet the sexual and reproductive health needs of sex workers begins with the objective of ensuring equity and a decent standard of life for all persons.

What is the Methodology will be used in the Study?

A qualitative study will be undertaken in the City of Nairobi. To participate in the study the participants will need to be 18 years and above. Focus group discussion and individual interviews will be conducted with sex workers in Kenya. The sex workers will be identified by the organisations working with them either directly or indirectly such as the Federation of Women Lawyers Kenya (FIDA Kenya). The interviews are aimed to give an in-depth understanding of the experiences of sex workers in a bid to realise their sexual and reproductive health rights in Kenya. The researcher will take
notes during the interview and for backup purposes audio record the interviews which will be strictly locked in the 2 researcher’s file cabinet. The access to these notes and recording will only be available to the researcher.

**Why Have I Been Invited to Participate?**

It is up to you to decide whether or not to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide not to take part you are still free to withdraw at any time and without giving a reason. By participating in this study you will have an opportunity in furthering the understanding of sexual and reproductive health rights in Kenya and give a voice to the situation of sex workers in enjoying these rights.

**How will Privacy and Confidentiality be Maintained?**

The information you give to the research during the interview will strictly anonymised and remain confidential as per the limitation of the law.

**Who will Participate in this Study?**

This study draws experiences from sex workers in Kenya, policy makers, judges, lawyers, non-governmental organisations, police officers and health care professionals.

**How Long will the Interview Take?**

The interview will take 45 minutes.

**Who is Conducting the Research?**

The researcher is a doctoral student at the University of Sussex in the School of Law, Politics and Sociology.

**Who has Reviewed the Study?**

The study has been approved by the Cluster-based Research Ethics Committee at the University of Sussex.

**Thank You**
Appendix K: Information Sheet for Professionals

Information Sheet for Professionals

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Study Title: Promoting Sexual and Reproductive Health of Sex Workers in Kenya: A Human Rights Approach

What is the Purpose of the Study?

The purpose of this study is to interrogate how a human rights approach would guarantee sexual and reproductive health rights of sex workers in Kenya. It seeks to understand the meaning of sexual and reproductive health and rights, the current legal situation of sexual and reproductive health rights whether it promotes or hinder these rights and how sex workers in Kenya can achieve sexual and reproductive health and rights.

What Motivates the Researcher?

Sexual and reproductive health rights are human rights and the use of human rights as framework to meet the sexual and reproductive health needs of sex workers begins with the objective of ensuring equity and a decent standard of life for all persons. This study recognises the enactment of the Constitution of Kenya 2010 which explicitly recognises the right to the highest attainable standard of health including reproductive health care together with an elaborate Bill of Rights. The Kenyan Constitution also provides for equality stipulating the Universal Declaration on Human Rights that all human beings including sex workers are born free and equal in dignity and rights.

What is the Methodology will be used in the Study?

A qualitative study will be undertaken in Kenya. To participate in the study the participants will need to be 18 years and above. The study will interview key informants to get the perspectives on the situation of human rights, the cases they have handled and how they have used the law to advance sexual and reproductive health rights. The key informants will include policy makers, judges, lawyers, non-governmental organisations, police officers and health care professionals. The sex workers will be
identified by the organisations working with them either directly or indirectly. Focus
group discussion and individual interviews will also be conducted with sex workers in
Kenya for their own experiences. The interviews are aimed to give an in-depth
understanding of the experiences of sex workers in a bid to realise their sexual and
reproductive health rights in Kenya. The researcher will take notes during the interview
and for backup purposes audio record the interviews which will be strictly locked in the
researcher’s file cabinet. The access to these notes and recording will only be available
to the researcher.

**Why Have I Been Invited to Participate?**

It is up to you to decide whether or not to take part in this study. If you do decide to take
part you will be given this information sheet to keep and be asked to sign a consent
form. If you decide not to take part you are still free to withdraw at any time and
without giving a reason. By participating in this study you will have an opportunity in
furthering the understanding of sexual and reproductive health and rights in Kenya and
give a voice to the situation of sex workers in enjoying these rights.

**How Long will the Interview Take?**

The interview will take 45 minutes.

**Who is Conducting the Research?**

The researcher is a doctoral student at the University of Sussex in the School of Law,
Politics and Sociology.

**Who has Reviewed the Study?**

The study has been approved by the Cluster-based Research Ethics Committee at the
University of Sussex.

**Thank You**
### Appendix L: A 15-Point Checklist of Criteria for Good Thematic Analysis

<table>
<thead>
<tr>
<th>Process</th>
<th>No</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcription</td>
<td>1</td>
<td>The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’.</td>
</tr>
<tr>
<td>Coding</td>
<td>2</td>
<td>Each data item has been given equal attention in the coding process.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.</td>
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<tr>
<td></td>
<td>4</td>
<td>All relevant extracts for all each theme have been collated.</td>
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<tr>
<td></td>
<td>5</td>
<td>Themes have been checked against each other and back to the original data set.</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Themes are internally coherent, consistent, and distinctive.</td>
</tr>
<tr>
<td>Analysis</td>
<td>7</td>
<td>Data have been analysed - interpreted, made sense of - rather than just paraphrased or described.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Analysis and data match each other / the extracts illustrate the analytic claims.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Analysis tells a convincing and well-organized story about the data and topic.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>A good balance between analytic narrative and illustrative extracts is provided.</td>
</tr>
<tr>
<td>Overall</td>
<td>11</td>
<td>Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.</td>
</tr>
<tr>
<td>Written Report</td>
<td>12</td>
<td>The assumptions about, and specific approach to, thematic analysis are clearly explicated.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>There is a good fit between what you claim you do, and what you show you have done - ie, described method and reported analysis are consistent.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>The language and concepts used in the report are consistent with the epistemological position of the analysis.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>The researcher is positioned as active in the research process; themes do not just ‘emerge’.</td>
</tr>
</tbody>
</table>

*Source Braun and Clarke, ‘Using Thematic Analysis in Psychology’ (2006)*