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VIEWPOINT

# The Frame That Kills: Post-Abortion Care, Colonial Penal Law, and the Right to Health

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On April 24, 2026, the Kenyan Court of Appeal at Malindi reinstated criminal proceedings against a girl who had been arrested at age 17 for receiving post-abortion care for an incomplete abortion and against the clinical officer who had treated her.[1] The judgment in *Kenya Christian Professionals' Forum v. PAK* will be read as a setback for abortion rights in Kenya, and in that frame, it is a setback. But the frame is the problem.[2] *PAK* is not, on its facts, an abortion case. It is a post-abortion care case prosecuted under abortion statutes, and in this viewpoint, we argue that the court of appeal's central failure was to allow the slippage between these two categories to govern the proceedings. Recognizing this slippage as the mechanism of harm reframes both the doctrinal failure and the violation of the right to health that the judgment entails.

The right to health imposes obligations on the state.[3] General Comment 2 on Article 14 of the Maputo Protocol issued by the African Commission on Human and Peoples' Rights establishes that women must not be arrested, charged, or prosecuted for seeking abortion services or post-abortion care, that they must incur no legal sanctions for benefiting from such services, and that states must train and sensitize law practitioners, judges, magistrates, and police officers to give effect to this protection.[4] Kenya has ratified article 14(1) of the Maputo Protocol without reservation, and the threshold obligation is operative in domestic law through article 2(6) of the Constitution.[5] The obligation is engaged the moment a patient is arrested for receiving post-abortion care or a provider is charged for offering it, regardless of whether the prosecution

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eventually succeeds. Conviction is not the harm. Prosecution is.

The mechanism by which this threshold obligation is violated requires careful naming. Sections 158, 159, and 160 of the Kenyan Penal Code, under which the petitioners were charged, are direct descendants of the English Offences Against the Person Act 1861, transplanted into colonial Kenya through the 1930 Penal Code.[6] They remain similar to the 1861 act, with the Kenyan provisions more expansive than the English original in their scope of criminal liability. They were drafted more than 160 years ago, in a clinical environment that did not recognize post-abortion care as a category.[7] Post-abortion care—the management of complications regardless of whether the abortion was spontaneous or induced—emerged as a distinct clinical practice only in the late 20th century and was subsequently recognized by the World Health Organization as essential emergency obstetric care.[8] The Kenyan Ministry of Health adopted post-abortion care as official policy in 2012, and in 2013 directed that it be made an integral part of free maternity services.[9]

Sections 158, 159, and 160 of the Penal Code predate this entire architecture and contain no recognition of the distinction between procuring an abortion and treating its complications. The colonial provisions cannot, in their text, reach post-abortion care. Sections 158 and 160 require proof that the accused administered drugs or supplied instruments with the intent to procure miscarriage.[10] Section 159 requires the woman to have acted with the intent to procure her own miscarriage.[11] The *mens rea* is temporally located at the moment of action upon a continuing pregnancy. A clinician treating a woman after the miscarriage has already commenced or completed has not administered drugs to procure a miscarriage. The miscarriage has occurred. The intervention is directed at its consequences. Intent cannot operate retrospectively upon what has already happened.

The *PAK* charges nonetheless alleged the procurement of abortion against evidence that uniformly described post-abortion care. The petitioner's affidavit, the clinical officer's affidavit, and the uncontroverted specialist evidence of Professor Joseph Karanja, an obstetrician who reviewed her medical records, all described an incomplete abortion presenting with bleeding, severe pain, and dizziness, managed clinically after the patient's arrival. The investigating officer's contrary assertion that no post-abortion care had been provided rested on no medical foundation.[12] The charges alleged conduct that the elements of the offenses could not reach. The proper response was threshold dismissal under the established Kenyan doctrine that prosecutions disclosing no offense constitute abuse of process, articulated in *Meme v. Republic* and *Commissioner of Police v. Kenya Commercial Bank*.[13] The court of appeal instead treated the case as a forum dispute about whether constitutional petitions are the proper vehicle for challenging prosecutions, accepting as given precisely what was at issue: that the conduct alleged matched the elements of the offenses charged. It did not.

## The frame slippage has a chilling effect

This is the frame slippage. A prosecution alleges abortion. Evidence describes post-abortion care. The court accepts the abortion frame, reinstates the prosecution, and treats the distinction between the two as a factual matter for trial rather than a legal matter for the threshold. The reinstatement is not neutral. It is itself the harm that the threshold obligation prohibits. By the time of acquittal—if acquittal comes—the patient has been arrested from a hospital bed, subjected to forced examination, detained for a month in juvenile remand, and put through years of criminal process. The clinician has been arrested at the workplace, had patient records seized, faced months in custody, and watched their professional reputation collapse. Other clinicians watch and learn. The systematic review evidence establishes that providers anticipate criminal justice procedures resulting from their clinical practice and that criminalization produces a chilling effect on health care provision, with negative implications for the rights to life, health, and privacy of women seeking care.[14]

The cost of this chilling is denominated in

deaths. Up to 14% of pregnancies in Kenya end in unsafe abortion, resulting in approximately 2,600 deaths annually, with severe complications most common among women aged 10 to 19 and a case fatality rate approximately nine times the rate in developed regions.[15] A 2024 study found that only 46% of primary-level facilities in Kenya had staff trained on post-abortion care, and only 16.6% had functional operating theaters or manual vacuum aspiration rooms.[16] The young, rural, economically marginalized women who bear this mortality share the petitioner's demographic profile. The legal architecture that the *PAK* judgment sustains shapes the clinical environment in which they live or die.

The right to health framework offers a remedy that does not require expanding the contested constitutional jurisprudence on abortion.[17] Courts can be asked to enforce, at the threshold of criminal proceedings, the distinction between abortion and post-abortion care that the clinical literature treats as foundational, that the colonial drafting of the Penal Code could not have anticipated, and that General Comment 2 requires states to maintain.[18] The argument asks courts to apply ordinary criminal law principles—the requirement that the conduct alleged match the elements of the offense charged—in light of uncontested clinical categories and uncontested human rights obligations.[19] It does not require courts to recognize abortion as a freestanding right; it requires only that they read criminal statutes faithfully.

*PAK* makes the requirement visible. The criminal law of Kenya does not, in its text, criminalize post-abortion care. We contend that the court of appeal, by allowing the frame slippage to pass unchallenged, permitted the criminal process to operate against post-abortion care in practice. The right to health framework demands that this gap between law and practice be closed. How long it remains open is now a question for every court that follows.

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