Pathways to African Feminism and Development- Journal of African Women Studies Centre, University of Nairobi (http://www.uonbi.ac.ke/journals/)

Volume 1. Issue 4. September 2016 ISSN 2309-3625

THE POT BEARER UNDERSTANDS ITS WEIGHT: AN ANALYSIS OF PRO-ABORTION DISCOURSES IN KENYA

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Abstract

The paper provides a detailed analysis of pro-abortion discourses in Kenya. It focuses on the arguments, philosophical principles, narratives and other important rhetorical strategies that are employed by pro-abortion actors in their struggle to achieve access to legal safe abortion in Kenya. The paper demonstrates that in an attempt to counter institutionalised foetal focused and moralising anti-abortion discourses espoused by anti-abortion crusaders, pro-abortion actors construct discourses that concentrate on the more politically acceptable realm of health complications and on the economic costs of unsafe abortion rather than on women's right to terminate a pregnancy. It is argued that the framing of the discourses is a result of neo-patrimonial politics, coupled with patriarchal tendencies, which have also enabled the institutionalization of anti-abortion discourses. Data for this paper was collected in 2009 in Kenya as part of PhD research.

Key Words: *Reproductive Health, Abortion, Discourse*

1.0 Introduction

Unsafe abortion remains one of the major causes of maternal mortality and morbidity in Kenya. Unsafe abortion is seen as contributing to between 30-50 per cent of maternal mortality and morbidity in addition to 60 per cent of all gynaecological admissions at public hospitals (Wamwana et al., 2006). A 2012 study showed that approximately 464,690 induced abortions occurred in Kenya in 2012 (African Population and Health Research Centre et al., 2013). This corresponds to an induced abortion rate of 48 abortions per 1000 women of reproductive age (15-49 years), and an induced abortion ratio of 30 abortions per 100 births. Of the performed abortions, the study estimated that 157,762 women received care for complications of induced and spontaneous abortions in health facilities (ibid.). Of these, 119,912 were experiencing complications of induced abortions and were treated at public hospitals. It is estimated that 266 Kenyan women die per 100,000 unsafe abortions, which translates into more than 1,200 women dying annually due to complications of unsafe abortions (ibid.). It is however possible that for every woman who seeks medical care at a medical health facility, many more have other complications and usually seek out homemade cures, pharmacists or some other untrained persons for assistance. These women are not included in the statistics.

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Although access to safe, effective contraception could substantially reduce the need for abortion, unmet needs for family planning remains high in Kenya, with one in four women having an unmet need (Ian et al., 2009). In fact, the study referred to earlier found that more than 70 per cent of women seeking post-abortion care were not using any method of contraception prior to becoming pregnant. Obviously, the likelihood that a woman will seek to terminate an unintended pregnancy increases with unmet needs for family planning. It is, in fact, generally agreed that one of the major ways of reducing the number of abortions is by giving women complete control over their own reproductive lives through making available contraceptives and information on their use.

2.0 The Legal Context of Abortion in Kenya

Prior to the adoption of the Kenya Constitution 2010, abortion was governed by the Penal Code (Cap 63 Laws of Kenya).[2] Under Sections 158,[3] 159,[4] and 160,[5] the law criminalized the woman and the person who provided the abortion, with the two liable for prison sentences of up to 14 years if found guilty. Section 240,[6] though, provided an exception by allowing for legal abortion to save a woman's life. Unfortunately, few medical health providers in Kenya were trained on the full provisions of the law and most women remained unaware of the law's exceptions, thus making safe and legal abortions rare.

Kenya's Constitution 2010 expanded the circumstances under which legal abortion could be offered. Although recognizing the right to life from conception, the Constitution provides a stronger protection for the lives and health of women. Whereas the previous law only allowed legal abortion to protect a pregnant woman's life, Section 26 of the 2010 Constitution explicitly permits abortion and clearly specifies the situations in which it is permitted. These include: (i) when there is need for emergency treatment, and (ii) where the life or *health* of the mother is in danger. Abortions can be offered following the advice of a trained health professional. Section 26 further provides a possibility of expanding the circumstances under which legal abortions can be offered by allowing the enactment of a law for that purpose.[7] Access to legal abortion is further enhanced by Article 43(1) (a), which provides that every person has the right to the highest attainable standard of health care services, including reproductive health care. This provision becomes stronger when read within the context of Article 43(2), which prohibits denial of emergency medical treatment.

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[2] This document is available at http://www.kenyalaw.org/Downloads/GreyBook/8.%20The%20Penal%20Code.pdf

[3] "Any person who with intent to procure miscarriage of a woman, whether she is or is not with child unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years." (Penal Code, p. 66)

[4] "Any woman who being with child with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any 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 fourteen years." (Penal Code, p. 66-67)

[5] "Any person who unlawfully supplies 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." (Penal Code, p. 67)

[6] "A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case." (Penal Code, p. 85)

[7] The judiciary or Parliament could enact law expanding the conditions under which legal abortion could be offered.

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Seemingly, the Constitution clearly provides for legal abortion. However, Kenyan women continue to lack access mainly because of lack of clarity in the law. For instance, it remains unclear who a trained health professional is, who qualifies for safe legal termination, when, where and how safe abortion can be performed since Parliament is yet to enact laws to give life to the provisions of the Constitution. The Ministry of Health had in September 2012 launched the Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion but these were withdrawn on 3rd December 2013 with the argument that there was need for wider stakeholder consultation on the contents of the document (Griffith, 2014). The Guidelines were the only existing document for health professionals addressing the conditions needed in order to procure a safe abortion (ibid.). Additionally, the Penal Code has yet to be amended to reflect the change in the constitution and abortion remains a criminal offence unless done to save a woman's life. The ongoing confusion surrounding Kenya's abortion laws creates uncertainty for women and medical doctors, who are also at risk of criminal investigation or punishment if their advice or treatment is deemed illegal.

Evidently, although unsafe abortion has figured increasingly in public discourse, it has yet to be conclusively addressed by the Kenyan state. As a result, the question of what ought to be done about it remains mired in ambivalence, obscurity and compromise, with the attendant problems of female mortality and morbidity being tacitly recognized[8] but only partially addressed. The Kenyan government, as exemplified by its failure to articulate a clear and consistent standpoint on the abortion issue, seems to have favoured the strategy of *strategic ambivalence* as a result of neo-patrimonial politics and patriarchy, both of which influence the interplay of gender discourses and political practices that shape the process of dealing with abortion. Neo-patrimonial politics significantly shape public policy making processes since patrimonial and clientele relationships often push state leaders into serving the interests of their political supporters, including, in most instances, tribal patriarchs and religious leaders, who are unlikely to support women's right to safe abortion. State efforts have therefore been directed at presenting a positive image of itself to both pro- and anti-abortion actors, rather than substantively tackling the problem of unsafe abortion.

3.0 Neo-patrimonialism, Patriarchy and Abortion

The concept of neo-patrimonialism[9] has been noted to mean different things to different scholars (Erdmann & Engel, 2007). Bratton and van de Walle (1997), for example, understand it to be a hybrid regime consisting of, on the one hand, an exterior modern, formal, rational-legal state-like apparatus, and on the other hand, a patrimonial spoils network in which centralised elites mobilise political support by using their public position to distribute jobs, rent-seeking opportunities, and resources as personal favours. Clapham (1985, p. 48) says a neo-patrimonial state is

[8] The government has allocated post-abortion care wards in many public hospitals

[9] Social scientists add the modifier neo- to patrimonialism to distinguish what they regard as a modern variant of Weber's (1947) ideal type with one in which patrimonial logic characterized by patronage, clientelism, and corruption prevails (Pitcher et al. 2009).

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"a form of organisation in which relationships of a broadly patrimonial type pervade a political and administrative system which is formally constructed on rational-legal grounds". Somewhat differently, Chabal and Daloz (1999, p.16) describe the modern African state as "no more than a décor, a pseudo-western façade masking the realities of deeply personalised political relations." What is in agreement in these definitions is that in African neo-patrimonial states, political power is personal and politics is a type of business wherein political positions give access to economic benefits (Bach & Gazibo, 2012; Fatton, 1990).[10]

Some researchers have located the origin of neo-patrimonialism in Africa in the colonial experience (Berry, 2000; Dia, 1996; Lentz, 1995; Mamdani, 1996; Pitcher et al., 2009).[11] These scholars argue that the colonial era exerted so much influence on societies in Africa that contemporary governance in the continent bears little resemblance to that of the pre-colonial societies. Englebert (1997, p. 768) has for example claimed that the contemporary problems in African states derive "from the very exogeneity of the state, its lack of embeddedness, its divorce from underlying norms and networks of social organisation." For him, the different values of the imported colonial state gave rise to a perception of illegitimacy in the minds of the colonised people, and consequently the belief that it was available for plunder (Englebert, 1997). As Achebe (1960, p. 30) observes, local people came to view the state as "an alien institution and people's business was to get as much from it as they could without getting caught."

It is noted that soon after the Berlin Conference of 1884-1885,[12] European colonialists partitioned Africa amongst themselves in a manner that reflected their spheres of influence, without paying regard to matters concerning ethnic heterogeneity or hitherto existing institutions of governance (Mamdani, 1996). Upon Independence, the artificial boundaries were maintained so that different ethnic groups, each with their own languages, culture, religion, traditions, customs and political and economic systems, were brought together to form single political and administrative units (Dowden, 2008). Forcing ethnic communities that previously lived independently of each other to live together, the colonisers did not give a thought to the possibility of the emerging states being ethnically and/or otherwise polarised.

The European idea of a mono-cultural nation-state left most post-colonial African states with the dilemma of how to unite ethnically and sometimes religiously plural societies (Chatterjee, 1993; Dia, 1996). Moreover, the numerous tribal patrimonial kingdoms encouraged by the colonialists' system of indirect rule[13] had led to the

[10] Some researchers, such as Erdman and Engel (2007), have noted that significant elements of patrimonialism survive and thrive even in the most highly industrialized present societies.

[11] It should be noted that some scholars have located the origin of neo-patrimonialism in pre-colonial patterns of behaviour in which patrimonial considerations are presented as having been paramount (Chabal & Daloz, 1999; Ekpo, 1979). Some other researchers also see the reality of contemporary Africa as being the product of both pre-colonial and colonial practices (Dia, 1996; Kohli, 2004).

[12] The Berlin Conference was held in Berlin between November 15, 1884 and November 26, 1885 for the purpose of dividing the continent of Africa between European powers (Dowden, 2008).

[13] As a result of scarcity of money and manpower, British colonialists ruled through local tribal leaders, particularly chiefs, to implement colonial policies (Berry, 1992; Jua, 1995).

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emergence of extremely powerful individual local intermediaries[14] who acted to limit the post-colonial state's infrastructural power (Bayart, 1993). In a bid to homogenise the otherwise heterogeneous groups, African leaders sought to centralize both the state and power, leading to the emergence of neo-patrimonial states.

Researchers have argued that because diverse pre-existing institutions were disrupted or constituted by colonialism, they could not generate loyalty and ownership among Africans. To compensate for the low or weak initial political legitimacy, post-colonial African leaders adopted neo-patrimonial and clientelistic strategies which temporarily afforded them the necessary "instrumental loyalty" of competing elites (Dia, 1996; Englebert, 2000). As Chabal (2002) observes:

> Politics at independence became patrimonial rather than institutionalised.... Despite their Western appearance, African political systems developed logic of patronage which relied almost entirely on networks of personalised and vertical relations between rulers and ruled: elite and populace. (p. 51)

Evidently, at its core, neo-patrimonial rule is governance based on assembling political supporters through patronage rather than issues. Although policies remain important, they are chosen on the basis of assembling clients rather than on appealing to citizen preferences.

4.0 Pro-abortion Actors in Kenya

The abortion debate in Kenya has been spearheaded by medical health professionals and specifically by the Kenya Medical Association. For example, since the 1993 Annual Scientific Conference of the Kenya Obstetric and Gynaecological Society (KOGS) at which members passed a resolution asking the Minister of Health to present a cabinet paper on abortion as a health issue, highlighting the social, economic and health costs to the country, this organisation has consistently demanded that the government make safe abortion available (Oguttu & Odongo, 2001).

Another visible organisation has been the Federation of Women Lawyers (FIDA), with whom the Kenya Medical Association has worked closely. In July 2004, the two organisations spearheaded the formation of the Reproductive Health and Rights Alliance (RHRA), a coalition of individuals and organisations advocating for the creation of a legal, political and social environment that supports sexual and reproductive health and rights, including safe abortion in Kenya (Kenya Human Rights Commission, 2010). Other member organizations include the Centre for the Study of Adolescents, the Coalition on Violence against Women, Family Health Options Kenya, the Kenya Human Rights Commission, the Kenya Obstetrics and Gynaecological Society, the Reproductive Health Rights Organisation (IPAS), the National Nurses Association of Kenya, individual activists, and representatives from law firms, among others.

[14] Mamdani (1996) has noted that indirect rule resulted in decentralized despotism, in which local chiefs were granted increased power with often weakened downward accountability.

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A significant factor that emerged in the course of this research is that, because key players in the abortion debate are medical health professionals, pro-abortion discourses in Kenya emphasise the expansion of access through a medical focus on the dangers of clandestine abortion, rather than direct advocacy for policy change. Although identifying abortion as a medical issue removes the procedure from its political, social and gendered context and effectively places control over the termination of a pregnancy within the medical domain, the involvement of doctors can be seen as not just imbuing the pro-abortion debate with the power of scientific medical authority, but also as providing a discourse devoid of feminist rhetoric. In a society where politics increasingly relies on stringently controlled and patriarchal gender relations, doctors' statements are likely to receive greater acceptance by political and ethnic leaders for being expert advice on a health and medical problem for which they are trained.

Another significant characteristic of Kenyan pro-abortion actors is their reliance on foreign organisations and funding. On the one hand, the presence of external actors advocating for and supporting the implementation of population policies has had the effect of presenting reproductive health in general and abortion in particular as foreign concepts. On the other hand, overreliance on foreign donor funding for financial and logistical support was also said to affect the identification of priority areas as well as the manner of programmes implementation. The head of an organisation working with youth sexuality, for example, said that, following the Global Gag Rule,[15] they had been unable to access funds that could help to effectively address the Kenyan youths' sexuality needs. Because the Global Gag Rule limited non-USA based organizations receiving USAID funding from speaking about unsafe abortion in the context of liberalization, her organisation had had to ignore abortion as a factor in youth's welfare, even though unsafe abortions are responsible for health complications and deaths amongst young Kenyan women. As such, although the organisation was a member of the Reproductive Health and Rights Alliance (RHRA), it was not leading any efforts directly for fear of losing funding.

Evidently, pro-abortion actors in Kenya work from an already disadvantaged position since they not only lack state and elite support but also have to struggle against a firmly institutionalised anti-abortion discourse. To this end, the pro-abortion activists have developed their own discourses with which they attempt to convince both the public and policy makers that access to safe abortion would have positive consequences for the society as a whole.

5.0 Pro-abortion Discourses in Kenya

5.1 Abortion as an Issue of Public Health

[15] On March 2001, President George W. Bush issued a memorandum to the administrator of USAID, reinstating a policy that required foreign nongovernmental organisations to agree as a condition of their receipt of federal funds for family planning activities that such organisations would neither perform nor actively promote abortion as a method of family planning in other nations. Under the Mexico City Policy (or Global Gag Rule), in order to receive USAID funding for family planning, foreign NGOs were prohibited from using their own funds to provide abortion services, provide counselling or referrals regarding abortion, or to lobby their own governments for abortion law reform (Restoration of the Mexico City Policy, 66 Fed. Reg. At 17, 303).

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> *A straightforward public health problem with a known solution has been allowed to become the killing fields of women in developing countries, particularly Africa (Sai, 2004, cited in International Planned Parenthood Federation (IPPF), 2006, p. 3).*

As noted in the above quotation, public health abortion discourses in Kenya, as elsewhere in Africa, focus attention on the health problems encountered by women due to unsafe abortions. Those in support of safe abortion argue that thousands of women die and many more suffer irreparable harm as a result of dangerous procedures conducted by unskilled persons. As already noted, of the 464,690 induced abortions performed in Kenya in 2012, 157,762 women received care for complications of abortions in health facilities (African Population and Health Research Center et al., 2013). It is estimated that 266 Kenyan women die per 100,000 unsafe abortions, which translates into more than 1,200 women dying annually due to complications of unsafe abortions (ibid.).

A notable characteristic of the focus on deaths from unsafe abortion is the attention paid to the fact that the problems result from the procedures being performed by untrained persons. As such, reports by pro-abortion actors are often accompanied by detailed information of the unhealthy conditions in which back-street abortions are procured. This may not be a coincidence. Rather, it is a strategic effort which enables pro-abortion actors to focus on the unhealthy conditions in which unsafe abortions are offered. This in turn provides them with the opportunity to demonstrate that if abortion were offered by trained health professionals, related deaths and health complications would be eliminated. By so doing, the health discourse posits that making abortion accessible can have a dramatic impact on reducing mortality and morbidity.

Additionally, pro-abortion actors' focus on the circumstances in which unsafe abortion occurs enables the shifting of blame away from women and abortionists and towards external agents, such as the state and religious organizations, which, by stigmatising abortion, make women submit to procedures that threaten their lives. On the one hand, the state is accused of failing to provide contraceptives and access to safe abortion while, on the other, it is charged with failing to provide sex education. A pro-abortion research participant explained that if the Kenyan government provided sufficient access to contraceptives, the number of unwanted pregnancies and the attendant unsafe abortions would be minimised. In fact, the majority of research participants acknowledged the relationship between unwanted pregnancies and unmet need for family planning as a key issue. A research participant working with the governmental body on population and development said the country has a 24 per cent unmet need for family planning. This participant explained that "reproductive health issues are not seen as important because unlike diseases like HIV/AIDS, tuberculosis, and malaria, pregnancy-related issues are considered normal. If a woman is pregnant, they see it as just natural."[16] Treating

[16] Kulczycki (1999) has claimed that one of the reasons behind the continued lack of recognition of problems resulting from unsafe abortions in Kenya is the fact that ill health is generally perceived as a natural part of being a woman.

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pregnancy-related issues as *normal* has the effect that little funding is allocated to maternal healthcare, and the social, political, cultural and economic factors that play a strong role in women's health are strategically ignored. Moreover, the ruling elite often are unwilling to spend money on an issue that is not only controversial but also seen as *unAfrican*. As a research participant explained:

> You see, if an MP's constituents were dying of malaria or cholera for example, he/she will be very quick to call a press conference and demand government action. It is highly unlikely that any politician will openly campaign for family planning or abortion, unless they want to lose their seat in Parliament.

Kenyan leaders' need to appear morally upright in the eyes of significant constituents, such as religious organisations and local patriarchs, was also identified as being behind the government's inability to provide sex education. A research participant working with a youth organisation said this was unfortunate because his organisation's study on adolescent sexuality had shown that sex education at the early stages of life can significantly prevent unwanted pregnancies. In Kenya, sex education can only be offered in the context of teaching about HIV/AIDS. To this participant, this has meant Kenyan teens have little or no knowledge on how to prevent pregnancy, since the little sex education they receive promotes abstinence as the only means of prevention. As a result of a campaign urging young people to *chill* or abstain from early sex, many young people in Kenya who know about the condom only know it as a means of preventing HIV/AIDS infection, but not as a birth control measure. This lack of information was identified as a major factor in unwanted pregnancies and abortion in Kenya. By failing to provide relevant sex education and contraceptives to young people, adults shut their eyes to the truth about teenage sex. This focus on contraception serves two functions: first, pro-abortion actors are able to present themselves as not being only interested in abortion, but also in the prevention of unwanted pregnancies. Secondly, it makes it possible to challenge anti-abortion activists who construct them as *abortion addicts*.

The public health discourse on abortion in Kenya has also focused on the amount of medical attention required by women who have incomplete or septic abortions, which they contend, negatively affects the management of other patients. Such patients were said to absorb much of nurses and doctors' working time, leaving Kenyan hospitals unable to attend to or admit other patients. This argument pointed to the fact that if easily accessible, abortion would be much safer and cheaper, as it would be openly performed in licensed clinics with better facilities.

In response to the claims of anti-abortion discourses that freely accessible abortion would lead to increased cases, pro-abortion actors argue that since restrictions have not ensured fewer abortions, accessibility would just move abortions from the backstreet into proper medical facilities. In fact, in countries such as Belgium, Germany and the Netherlands, where safe abortion is widespread and modern contraceptive use is high, the abortion rate is very low at 10 per 1000 women of reproductive age, whereas in Africa, despite the legal restrictions and inaccessibility,

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abortion rates are high at 30 per 1000 women of reproductive age (Sedgh et al., 2007). Inaccessibility and restrictions can also be seen as responsible for preventing victims of unsafe abortion from seeking timely post-abortion care due to fear, ignorance about services, and stigma, in addition to the prohibitive cost of post-abortion care. As a result, the majority of women go to public hospitals only when complications are severe and complex, requiring more resources and extended hospital stays.

As already noted, leaders in Kenya often avoid taking a position on abortion as this could lead to either gaining or losing votes from abortion proponents and opponents. Analysis of policy-making across different contexts has shown that individual politicians and bureaucrats often play central roles in championing issues as well as getting them onto the policy agenda (Grindle & Thomas, 1991; Shiffman, 2007). Consequently, if Kenya's bureaucracy perceives no political benefits in championing safe abortion, the issue is not only unlikely to attract political entrepreneurs to champion it, but it is also likely to be deprioritized and only referred to *in passing*.

In sum, then, the pro-abortion public health discourse in Kenya posits that access to abortion is a crucial part of ensuring high quality healthcare for women. This is because limiting access to abortion exposes women to health complications and death.

5.2 The Economic Cost of Abortion

Pro-abortion economic discourses in Kenya pay attention to the material cost of abortion related problems and to the advantages that would accrue, for both individual women and the national economy, if safe abortions were accessible. Unsafe-abortion related morbidity and mortality is presented as imposing a huge cost on the lives and health of Kenyan women, while at the same time burdening the country's public health system. The following excerpt from a publication provided by one of the organisations that I visited during fieldwork clearly captures the economic losses that may accrue to individual women as a result of an unsafe abortion:

> In order to earn money to feed her family, Sarah was forced to leave school at age 13. When she couldn't find work washing clothes she would have sex with men for money. She would earn 100 shillings (less than $2.00 USD) from these encounters to buy food for the family. When Sarah became pregnant, a woman in Kibera[17] advised her to get an abortion. Sarah procured an unsafe abortion from the woman's friend, and soon developed a dangerous, life-threatening infection which left her in great pain and bed-ridden for a month. The cost of emergency healthcare and the fear of arrest kept her from going to a hospital. Sarah and her mother were afraid to talk to anyone about how sick she was because of the risk of arrest and the fear of community condemnation. Sarah died at home on June 29, 2009. Her family now

[17] Kibera is an informal settlement [a slum] in the outskirts of Nairobi

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> goes for days without food and survives on hand-outs from neighbours in Kibera (Center for Reproductive Rights, 2010).

As demonstrated by Sarah's case, in addition to the morbidity and mortality associated with unsafe abortion, women and their families also incur economic losses. The economic costs are related to loss of productivity and increased health problems for those women who survive, as well as the impact on their extended family. A research participant noted that in Kenya, a significant number of women who have abortions have other children, are in relationships, and are usually not procuring their first abortion. As such, the possible death of a woman or even a long incapacitating complication would exact a heavy economic toll on her family. This is more so in Kenya where women can be responsible for up to 100 per cent of household income and for the welfare of their families. In fact, according to the World Health Organisation, an estimated quarter to half a million children around the world lose their mothers each year as a result of unsafe abortion (Grimes et al., 2006). These children are more likely than children with two parents to receive inadequate health care and social services such as education, and are more likely to die at an early age (World Health Organisation, 2005).

Moreover, as noted above, due to a variety of factors, unsafe abortion tends to affect poor women in Kenya. Consequently, it is likely that monetary costs for the procedure, as well as the cost of post-abortion care, can further increase women's poverty. The fact that abortion is easily accessible means that the cost of abortion services is unregulated and is therefore generally high. As such, poor Kenyan women, who normally have to wait longer to confirm their pregnancies due to lack of access to pregnancy tests, usually defer abortion until their second trimester, by which time they will have saved enough money for the payment. Unfortunately, second trimester abortions are more often accompanied by greater complications, longer hospital stays, and, inevitably, greater expense.

At the national level, the treatment of abortion-related complications in public hospitals was said to consume significant resources, including hospital beds, blood supplies, medications, and often operating theatres, anaesthesia and medical specialists (Kiberenge & Kiarie, 2010). A pro-abortion health professional who participated in the study noted that:

> The impact on the resources of Kenya's healthcare system is enormous. For example, as much as 60 per cent of the resources of Kenyatta National Hospital's maternity ward are being taken up by victims of unsafe abortions. If you walk into that ward, you will be surprised to discover that more than half of the women have not given birth. In fact, it would be better if they had because having a baby is almost 10 times cheaper than treating a victim of unsafe abortion.

Another research participant, the head of a health institution in Nairobi, said that the approximate annual cost of the management of complications resulting from unsafe abortions to be about 300 million Kenya shillings (about USD $4 million). He

explained that treating complications from unsafe abortion significantly strains the already limited funds, staff, and medical supplies available to Kenya's public health system by diverting scarce resources to an easily preventable public health problem.[18] At the international level, the annual cost of unsafe abortion in Latin America and Africa is estimated to be between US$159 million and US$333 million (Vlassoff et al., 2009). These figures seem to suggest that if legal and accessible, funds spent on complications resulting from unsafe abortion could be put into better use such as providing contraceptives.

Seemingly, the economic burden of unsafe abortion to households and on health systems is great, given both the scale of the problem and the high cost of treating complications. This pro-abortion economic discourse implicitly suggests that alternatives to unsafe abortion, such as contraception or safe abortion services, are more cost-effective. Although this argument strengthens the case for the elimination of unsafe abortion, it is evident that like the public health discourses, it fails to raise the issue of women's right to control their own reproductive capacities. Abortion as a women's right is discussed below.

6.0 Human Rights Abortion Discourses in Kenya

As has already been established, the most commonly used pro-abortion discourses in Kenya include public health, with explanations of the social, political and economic causes of unsafe abortion, and descriptions of consequent suffering and deaths. Pro-abortion discourses make note of the culpability of government policies and societal stigmatisation in causing unwanted pregnancies and unsafe abortions, and also the roles of poverty and gender discrimination. In this section, I focus on the pro-abortion rights discourse. It will become apparent that due to multiple factors, discourses framing abortion as a women's right are largely absent in Kenya.

Around the world, feminist and women's movements have been at the forefront of campaigns for abortion liberalization. Most feminist movements define reproduction in terms of a woman's right to choose, and the liberalization of abortion is usually presented as an indispensable condition for achieving reproductive freedom and gender equality (Engeli, 2009; Fegan, 2002). However, as noted earlier, an abortion rights discourse is generally absent in Kenya because pro-abortion actors, led by medical professionals, focus more on public health and economic discourses, which in turn have had the effect of silencing a rights discourse. Thus, although some women's and human rights organisations have actively participated in the abortion debate, they too make reference to the health discourse in their *public* debates on access to safe abortion. In this context, I use the term *public* to refer to situations where a generalised audience may be the target, such as press addresses. Notably though, when the same actors participate in what I refer to as *private* contexts, such as organisational publications, conference presentations and even during interviews

[18] The funding issue is exacerbated by the fact that the government of Kenya allocates little funding to health care services. In 2001, African heads of states met in Abuja (Nigeria) and committed to allocating at least 15 per cent of annual budgets to the health sector. In Kenya however, government spending on health is not only less than half of the Abuja target and has been declining, but also Kenya has the lowest allocation in East and Southern Africa (Chuma & Okungu, 2011).

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for this study, the majority of the actors make reference to women's right to control their reproductive capacities. For example, when asked how the Federation of Women Lawyers (FIDA-Kenya) defines abortion, a lawyer within the organisation explained:

> In our Draft Reproductive Health and Rights Bill 2008, we are looking at abortion as a health issue because a lot of women are dying. Even for those women that do not die, many end up with lifelong disabilities so that they are unable to live normally afterwards. Again, women are affected economically because they spend their little money in paying for treatment after developing complications or in paying for the abortion itself.

It might have been expected that FIDA-Kenya, being a lawyer's organisation, would articulate pro-abortion discourses in the language of democracy and human rights. However, this participant's observation of a Draft Bill that was to purportedly guide abortion law liberalization and implementation in Kenya makes no reference to women's rights to safe abortions. Surprisingly though, when the same participant talked about her own opinion on abortion, she was categorical that, "all women have a right to decide when to have children." Contextually differentiated discourses are also identifiable in the case of women political leaders such as Martha Karua and Charity Ngilu, both former female Presidential candidates.

It is therefore plausible to argue that a pro-abortion rights discourse in Kenya exhibits two distinct characteristics. The rights discourse is prevalent when the target audience or readership is presumably pro-abortion, and absent in public debate. The need to front two distinct arguments targeting different audiences may be twofold. First, it may be donor driven, as most pro-abortion women's and human rights organisations, including FIDA Kenya, are funded by international foreign organisations. I contend that because international organisations working on abortion in Kenya (most of which happen to be American) tend to prioritize the rights discourse, the presence of this discourse in workshops, conference papers and other publications may be either because the organisations produce the documents themselves,[19] or direct the content of the publications as funding agencies. Secondly, because the public debate on abortion takes place in a mainly patriarchal, neo-patrimonial environment in which women's rights are rarely recognised, pro-abortion actors are inclined to reframe their discourse in a way that recognises the prevailing socio-political constraints. In order to survive politically, the two women politicians referred to earlier must adopt positions that do not antagonise their constituents, most of whom are religious and *publicly* anti-abortion.

It is important to note that male politicians in Kenya are also often faced with the need to articulate differentiated opinions. For example, during a mock tribunal organised by the Kenya Human Rights Commission (KHRC) and the Reproductive

[19] For example, the Guttmacher Institute and the Center for Reproductive Rights, both USA based, have published detailed materials on abortion in Kenya.

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Health and Rights Alliance (RHRA) in 2007, Dr Enoch Kibunguchy, a Member of Parliament and Assistant Minister for Health, called for the legalisation of abortion, accusing religious leaders opposed to decriminalisation of dishonesty (Njeri, 2007; Onyango & Mugo, 2008). He is noted to have said, "It is true I have helped nuns and priests' mistresses procure abortions, and most of my fellow gynaecologists in town [Nairobi] would say the same if they were honest" (allAfrica.com, 2007). However, following a press conference in which the Executive Secretary of the Catholic Health Commission condemned the Member of Parliament's claims and dared him to "stand firm and repeat his statement to his constituents so that they may judge him and his actions at the next general elections", the MP retracted his story, saying he had only helped one former nun to terminate an incomplete abortion while working in a government hospital (ibid.). It is obvious that for this Member of Parliament, as for the two female politicians referred to earlier, their personal principles are overruled by political realities.

Although the need to win public support may help explain women's and human rights organisations' avoidance of expressing explicit pro-abortion rights discourse in public, the majority of pro-abortion research participants were themselves of the opinion that the organisations had actually not done much towards ensuring access to safe abortion. The participants' claims were supported by my own observations that mainstream women's organisations avoid tackling the issue, choosing instead to focus on less controversial issues such as poverty, violence against women, female circumcision and HIV/AIDS. For example, after making numerous attempts to have an interview with any senior official from the *Maendeleo ya Wanawake Organisation* (MYWO), I was eventually told none wished to be interviewed because they were uncomfortable with the area of my research. Evidently, although unsafe abortion kills and maims thousands of women every year, the largest women's organisation in the country chooses to ignore it.

The evident lack of commitment to the abortion issue by the larger women's organisations was blamed on their leaders' unwillingness, rather than their inability, to bring to the fore Kenyan women's reproductive rights. Instead, the leaders were said to have been swayed by neo-patrimonial and tribal politics, all of which have hindered the formation of a strong women's movement. Additionally, many leaders of women's organisations seem to have joined these organisations because of the publicity that the leaders may get, rather than because of their commitment to feminist ideals. This is evidenced by the fact that most female parliamentarians in Kenya, as well as those holding senior government positions, previously worked with non-governmental organisations, and particularly women-related ones, before joining politics (Mburia et al., 2011). It is possible that the leaders use the organisations as a means of testing their popularity as well as a good networking opportunity from where they are able to meet tribal leaders who hold sway in elections. Such leaders are therefore unlikely to pursue issues that could make them appear like radical feminists, which could jeopardise their being appointed to plum state jobs or election as Members of Parliament or other positions.

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As the above discussion suggests, although a rights based discourse is explicit when the target audience and/or readership is presumed to be pro-abortion, it is largely absent when the audience is assumed to be anti-abortion or mixed. While this may be a reflection of donor preferences, it is also a result of the nature of politics in Kenya wherein political leaders avoid dealing with controversial issues for fear of losing potential votes. Moreover, the government has in the past co-opted women's organisation which has had the effect of making them apolitical. Such organisations are unlikely to pursue women's abortion rights. Additionally, because most leaders of women's organisations often harbour political ambitions, they are often reluctant to pursue controversial issues that could make them less attractive to tribal and ethnic leaders who hold sway in political elections as well as to the general electorate. As such, the women leaders ignore the issue of unsafe abortion, while choosing to concentrate on the more acceptable health and economics discourse of abortion. However, as I will show in the next section, prioritising these discourses has implications that are not necessarily beneficial to women.

7.0 Implications of Public Health and Economic Pro-abortion Discourses

As noted above, the public health pro-abortion discourse is premised on the belief that all women should be able to obtain safe and affordable abortions if and when they desire them. To the pro-abortion actors, access to safe abortion services is a crucial part of ensuring high quality healthcare for women. They argue that as a result of inaccessibility, thousands of Kenyan women have abortions performed by unskilled persons in unsafe conditions, and many die or suffer health complications. This does not only affect negatively any attempts to reduce maternal mortality and morbidity, but also results in funds being spent on a problem that could have been prevented. However, the privileging of public health discourse, which also places control over abortion within the medical health fraternity, can be said to have had varied consequences, both positive and negative.

Identifying abortion as a public health issue allows for a transition away from the traditional focus on individual women's behaviour toward attention to the environments in which unwanted pregnancies happen. As such, in their support for policy changes towards accessible abortion, pro-abortion actors in Kenya point to the fact that it is not possible to understand abortion, or the factors that influence women's abortion decisions, without an awareness of the conditions of the women's lived realities. They thus acknowledge the need to address the material conditions, such as patriarchy, poverty, sexual abuse, and lack of sex education, that expose women to unwanted pregnancies. Arguing that poor and younger women are not only more likely to have unwanted pregnancies but also to turn to unsafe abortion providers, pro-abortion actors posit that dealing with unsafe abortion would need to go hand in hand with addressing the factors that lead to unwanted pregnancies. To this end, pro-abortion actors insist that women of all ages be granted more access to and knowledge about contraceptives and birth control.

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However, although framing abortion as a public health issue and the consequent resonance with mainstream ideals such as the attainment of Millennium Development Goals or Vision 2030 may have enabled pro-abortion actors to widen their support base by winning a significant proportion of popular support and elite allies, it also has the potential to deliver two contradictory consequences: depoliticization of the issue and the marginalization of the discourse of women's right to abortion.

Depoliticization involves the suppression and replacement of the political element of social phenomena with a seemingly apolitical and technical perspective in policy and decision-making (Haines, 1979; Krippner, 2011; Lovenduski & Outshoorn, 1986). As a tactic, depoliticization works through the adoption of rule-based systems that are theoretically insulated from political pressures or that significantly diminish the discretion of politicians (Buller & Flinders, 2005; Burnham, 2000; Flinders & Buller, 2006). In relation to abortion, depoliticization usually involves abortion being defined as a technical issue, for which medical experts ought to take responsibility (Lovenduski & Outshoorn, 1986). When abortion is seen in this way, to argue against abortion is to argue against a doctor's decision about what is best for a patient. In Kenya, the fact that mainstream pro-abortion discourses mainly focus on the public health and to some extent the economic implications of unsafe abortion clearly points toward depoliticization. By concentrating on the tragic outcomes and costs of unsafe illegal abortions, these discourses explicitly suggest that the only way in which the social and economic consequences of unsafe abortion can be avoided is by allowing health professionals to provide safe abortions. Moreover, by emphasizing the benefits that would accrue if abortions were offered safely by skilled individuals, depoliticization provides pro-abortion actors with an opportunity to position themselves as *lifesaving* champions, while associating the efforts of anti-abortion groups with danger and death. By evoking images of butchered women left bleeding to death as a result of botched abortions, depoliticization not only discredits the anti-abortion construction of women seeking abortion as immoral, but also helps in concretising the medicalization of abortion.

The influence of depoliticization is evident in Kenya's 2010 Constitution, in which health professionals were accorded the right to determine the circumstances in which an abortion could be legally provided. Although this goes against feminist ideals by giving doctors power over women's reproductive choices, presenting abortion as a medical condition helped galvanise support for the Constitution's adoption during the 2010 referendum. Consequently, it can be argued that medicalization of abortion may be a strategy borne of the realization that arguments grounded in the language of reproductive rights and privacy, which are common in the United States of America but absent from the Kenyan scene, could have generated negative feelings in the largely Christian and patriarchal community.

Medicalization of abortion has an additional advantage. By presenting abortion as a public health issue, pro-abortion actors have been afforded an opportunity to characterise demands for safe abortion as demands for an essential health care

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service. This, coupled with the construction of victims of unsafe abortion as poor and generally marginalised women, also helps address the issue of access rather than just the legality of abortion. Silliman et al. (2004) explain how in the United States of America, failure to make abortion funding and access more prominent in the pro-choice campaign accentuated race and class divisions. Because the mainstream movement was primarily concerned with the legal right to abortion, abortion remains inaccessible for many women, but more so for poor and marginalised women in the USA. Furthermore, as shown by countries such as Zambia and Ghana, legalisation of abortion is a necessary but insufficient step toward improving women's reproductive health. In these countries, although abortion is legal, access to competent care remains restricted because of other barriers such as funding service provision and perceived poor quality of care (Castle et al., 1990). As such, the classification of abortion as a medical care service, alongside others, in Kenyan pro-abortion discourses, compels medical health providers, including those who might be anti-abortion, to provide the procedure for women in need.[20] This is especially crucial because religious organisations not only provide almost a third of health care services in Kenya, but in some areas, they are the only providers. In such areas, religiously run health institutions' refusal to provide safe abortions would leave women susceptible to unsafe but legal abortions if they have to turn to unqualified providers.

At another level though, while depoliticization has allowed Kenyan pro-abortion activists to counter anti-abortion discourses that present foetuses as the only losers in abortion cases, the pro-abortion discourses nevertheless shift attention away from women with unwanted pregnancies to the consequences that their abortions could have on other sectors of society, rather than on themselves. By extolling the public health and economic costs of unsafe abortion, the discourses depoliticize the issue by obscuring political aspects of abortion such as patriarchy and power dynamics in a male-dominated society, and how these contribute to unwanted pregnancies. As already demonstrated, economic forces and social structures, such as poverty, contraceptive unavailability and sexual violence, play an important role in influencing women's reproductive choices. Thus, while providing abortion for health reasons grants some women access to safe legal abortions, it does not extend the same to the majority of Kenyan women seeking abortion for economic and social reasons, to single mothers and young women in difficult circumstances, or to victims of contraceptive failure. These women are likely to continue seeking unsafe abortions from untrained individuals. Moreover, considering that many unsafe abortions in Kenya are procured by poor married women and younger women, depoliticizing abortion ignores *political* issues of spousal rape (which the male dominated Kenyan Parliament has failed to legislate against).

Additionally, feminist researchers have contested the medicalization and the consequent depoliticization of abortion with arguments that women's struggle for

[20] It is notable that there exist conscience clauses, which allow healthcare providers to refuse to provide abortion if it goes against their personal moral or religious convictions (Guttmacher, et al., 1998). Conscience clauses however normally do not apply in emergency situations, such as when the woman's life or permanent health is at risk.

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better reproductive and sexual health is a political struggle for control over their bodies, and not merely a demand for the expansion of medical health services (Sheldon, 1997). These feminists have questioned the rationale behind placing control over termination within the medical domain by requiring the permission of a doctor and/or doctors. They have argued that this practice presents the doctor as best situated, based on medical expertise and presumably inherent wisdom, to assess women's needs and best interests (Sheldon, 1997). This in turn represents women as inadequate, unstable, or unwise decision-makers, as observed by a pro-abortion research participant:

> The abortion law for example, is a barrier to women making their own decision on reproduction. Even if a woman is in danger of dying because of a pregnancy, it is the doctor to make the decision to terminate it. That is what the law requires. Even in a case where the woman makes the decision, the doctor can refuse. So the woman is totally out of the picture in the decision making process although she is the one carrying the pregnancy. Women are human beings. So why can't they be trusted to make the right decision? That is an abnormality we have to correct. (NSA1)

To feminist researchers, as well as to this participant, the ascription of decision making authority to doctors not only reinforces stereotypes of women as people who lack reason, maturity, sanity, and the ability to assess their own interests, but also complicates and pathologizes a relatively simple procedure (Leslie, 2010). Moreover, placing abortion in the medical field fails to acknowledge the fact that most women, at least in Kenya, have abortions for socio-economic rather than medical reasons. As such, I argue that legalising abortion on health grounds, as the new Kenyan Constitution has done, leaves the majority of Kenyan women exposed to the dangers of illegal unsafe abortions.

Conclusion

In this paper, I have analysed pro-abortion discourses in Kenya. I have shown that unlike women's movement-led abortion law reform campaigns in developed countries, the pro-abortion campaign in Kenya is spearheaded by medical health professionals and therefore tends to mainly concentrate on health complications resulting from unsafe abortion. To a lesser extent though, the pro-abortion actors also pay attention to the economic costs of unsafe abortion to the country as a whole as well as to individual women. I have shown that the institutionalization of anti-abortion discourses and the strategic ambivalence of Kenyan political leaders as a result of neo-patrimonial politics and patriarchy have influenced this framing of pro-abortion discourses. This framing has had the effect of side-lining a discourse asserting a woman's right to terminate a pregnancy. Although it is plausible to assume that the Kenyan pro-abortion actors could have considered public health arguments to be more forceful in a generally overtly religious and patriarchal society, other factors may also be at play. Firstly, a health and economic discourse resonates

well with the political elite who tend to avoid controversial issues. Secondly, a health and economic discourse also resonates with the wider government developmental goals and more specifically the Millennium Development Goals and Kenya's Vision 2030. On the negative side, I have shown that the pro-abortion actors' failure to construe abortion as choice, coupled with the fact that it is often left for doctors to determine when a woman can lawfully have an abortion, implicitly perpetuates the perception that abortion is an abnormal act for which permission must be granted by a higher authority to those women who are *unlucky* or *foolish* enough to need it. But, research in Kenya has showed that Kenyan women do actually make conscious decisions to have abortions (Izugbara et al., 2009).

It is also worth noting that in their attempt to challenge anti-abortion discourses that present abortion as harmful to women's health, pro-abortion actors have not utilised research already conducted in America and Europe that has proven the safety of abortion. In fact, the pro-abortion actors have not even dwelt on the fact that the abortion law is a colonial legacy and that prior to colonialism and the introduction of both Islam and Christianity into Kenya, abortion was an acceptable way of dealing with certain kinds of unwanted pregnancies. This, I suggest, would provide a powerful counter-claim to anti-abortion discourse that presents abortion as unAfrican. In fact, some African scholars have intimated that discourses that present abortion as dangerous for women are relatively new. Hunt (2007, p. 17), has, for example, noted that in Africa, abortion has always been "*a banality in many African women's lives, easily obtained, often safely performed, and enabling them less to limit total numbers of births than to control their timing in relation to marriage, initiation, other births, schooling, vocational matters, and the opinions of others*." In her opinion, medicalization of abortion following European occupation is what exposes women and girls to greater risk from botched abortions. Researchers in Kenya (Lema & Njau, 1990) have shown that in traditional societies, there always were known providers of abortion services who relied on traditional methods such as herbs and massage.

I have also shown that the absence of a women's rights approach to abortion is also related to the neo-patrimonial nature of Kenyan politics. In addition to politicians avoiding the issue because of the fallout that could result from either opposing or supporting abortion, neo-patrimonialism has weakened the women's movement and therefore the ability of women's organisations to comprehensively campaign for women's rights. Moreover, because leaders of women's organisations often have political aspirations, they also tend to avoid dealing with controversial issues.

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