

Implementing Reproductive Health and Abortion Provisions In The Kenya Constitution (2010)

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Abstract: Kenya's 2010 Constitution, although recognising the right to life from conception, provides a strong 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(4) 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.¹ 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. Unfortunately, more than seven years after the inauguration on the constitution, Kenyan women continue to be deprived of essential reproductive health services including quality maternal health care and safe and legal abortion services. This paper seeks to provide an analysis of the opportunities for safe abortion as provided in the 2010 Constitution, as well as examine the challenges that have hindered provision of safe legal abortions in Kenya.

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I. BACKGROUND TO INFORMATION

Abortion remains one of the world's mostly highly contested issues, and is surrounded by debate and activism. According to Press and Cole (1999, p.1), abortion is "one of the most contested social issues of our time, one firmly straddling the problematic intersection of public policy and private life." As a result, it has been a central issue for contemporary international feminism, and its centrality in policy has been compared to "what the suffrage issue had been to the feminist movement around the turn of the 20th century" (Dahlerup, 1986, p.10). Feminist concern about abortion has focused on its perceived connection to the legal and political constructions of what it means to be a woman citizen of a nation state, how this ties in with the meaning of justice and democracy, and how other social and political differences beyond gender – such as sexuality, ethnicity, religion, and class – fit into a hierarchy of citizenship underwritten by the institutions of the state (Smyth, 1998). Historically, the abortion question has sparked major controversy in Western liberal democracies and it remains a politically explosive social issue in many parts of Africa including Kenya.

Campaigns for the legalisation of abortion peaked in Western Europe, North America and Latin America in the 1960s and 1970s (Lovenduski & Outshoorn, 1986), but it remains a taboo subject in many parts of Asia and Africa. In their arguments, anti-abortionists focus on the moral dimensions of the issue in relation to the rights of the unborn, and therefore actively support criminalising women and abortion providers, and making abortions illegal (Petchesky, 1986). On their part, pro-abortionists have advocated safe abortion as a public health goal and legal abortion as a woman's right (Berer, 2002). The right of women to decide whether to have an abortion has been pursued by feminists, who perceive imposed abortion restrictions as instruments of social control (Petchesky, 1986). Feminists have insisted that when abortion is provided on broad socio-economic grounds and at a woman's request, and when safe, accessible services have been put in place, unsafe abortion disappears and abortion-related mortality and morbidity are reduced to a minimum (Berer, 2004; Sedgh et al., 2012). In fact, when abortion is provided with proper medical techniques and care, the risk of death is negligible and nearly 14 times lower than that of childbirth (Sedgh et al., 2012), as evident in the United States of America and in European countries such as the Netherlands. In the United States, for example, the death rate due to abortion complications fell by more than 50 per cent in the five years following legalisation (Tietze, 1984).

¹ The judiciary or Parliament could enact law expanding the conditions under which legal abortion could be offered.

In contrast to Western democracies, in the former Soviet Union and most Central and Eastern Europe countries, abortion on request became policy prior to the use of modern contraceptives (Stenvoll, 2007). It was the primary method of birth control (Stloukal, 1999) mainly because contraceptives were seen as unnatural, inefficient and/or dangerous (Kulczycki, 1999). After the collapse of the Soviet Bloc in 1989, however, abortion rights were among the first to be threatened by virtually all of the post-socialist governments (Kligman & Gal, 2000). Yet, despite growing political conflict around the issue in countries such as Hungary, Lithuania, the Czech Republic, the Slovak Republic, and the former German Democratic Republic, abortion policies have remained relatively permissive (Flood, 2002). In Romania, Bulgaria and Albania, restrictive abortion regimes that existed prior to the transition have been liberalised, leading to reduced abortion mortality (Grimes et al., 2006).

The situation has been different in most developing countries, where almost all unsafe abortions in the world are now carried out. In these countries, restrictive abortion laws were introduced by European colonial powers that have since changed their laws, but unsafe abortion is yet to be addressed by policymakers, even though it has been identified as a significant health and social problem (Grimes et al., 2006; Kulczycki, 1999). It is notable that in India, elective abortion was legalised as part of population policy under the Medical Termination of Pregnancy (MTP) Act (1971) and MTP Rules (1975) (Iyengar & Iyengar, 2002), while some African countries, including Benin Republic, Burkina Faso, Chad, Guinea, Mali, Ghana, Zambia, Ethiopia, Tunisia, and South Africa, have also liberalised their laws (Braam & Hessini, 2004; Gebreselassie et al., 2010). However, in many other developing countries in Africa, including Kenya, the abortion issue remains a delicate one, presenting a complex moral and ethical dilemma to governments and policy makers (Oye-Adeniran et al., 2002). This is despite the fact that unsafe abortion remains a leading cause of death among women of childbearing age. According to the World Health Organisation, more than 6 million unsafe abortions occur in Africa annually, resulting in 29,000 deaths, more than half of the world's estimated 47,000 deaths (Mesce & Clifton, 2011). Additionally, Africa has the world's widest range of abortion rates, with Middle and Eastern Africa having rates as high as 38 and 36 abortions for every 1000 women (Sedgh et al., 2012). It is evident from these figures that restrictive abortion laws have not led to a reduced need for abortion.

Unsafe Abortion in Kenya

Unsafe abortion remains one of the major causes of maternal mortality and morbidity in Kenya (Ministry of Health, 2005). The World Health Organisation (WHO) defines unsafe abortion as a process of terminating pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 1992). In Kenya, unsafe abortion is seen as contributing to between 30-50 per cent of maternal mortality and morbidity (Otsea, 2004), in addition to 60 per cent of all gynaecological admissions at public hospitals (Gebreselassie et al., 2005; Wamwana et al., 2006).

A 2012 study shows that approximately 464,690 induced abortions occurred in Kenya in 2012 (African Population and Health Research Center 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 (ibid.). Of the performed abortions, the study estimated that 157,762 women received care for complications of induced and spontaneous abortions in health facilities in the same year (ibid.). Of the abortions, 119,912 were experiencing complications of induced abortions. It is estimated that 266 Kenyan women die per 100,000 unsafe abortions.

Although access to safe, effective contraception could substantially reduce the need for abortion, unmet need for family planning remains high, 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 postabortion care were not using a method of contraception prior to becoming pregnant (African Population and Health Research Center et al., 2013). A major reason behind the low use of family planning is poor access to contraceptive services and frequent stock-outs as well as cultural norms and practices that place decision making authority regarding number of children on the man (Kenya National Human Rights Commission, 2012). The 2014 Kenya Demographic and Health Survey revealed that about one in four married women of reproductive age have an unmet need for family planning, which translates into approximately 1.4 million women.² Half of these women wanted to space their next birth and the other half did not want to have any more children. Specifically, 43 per cent of pregnancies in Kenya are unplanned (ibid.).

Moreover, contraceptives are often unavailable in government hospitals, government health centres, and clinics, which provide contraceptives to 57 per cent of users (Kenya National Bureau of Statistics & ICF Macro, 2010). Although they are available in private hospitals and pharmacies, the price is usually prohibitive. For instance, when they are available, female condoms retail at a cost of up to US\$2, more than ten times the

² <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

cost of a male condom. Not surprisingly, 45 per cent of pregnancies in Kenya are unintended (Anyangu, 2009), driving up the rate of illegal terminations.

Furthermore, because international donors such as the United Nations Population Fund (UNPF) and the United States Agency for International Development (USAID) have historically covered the costs of all contraceptives in Kenya, a shift in international attention to HIV/AIDS programmes since the 1990s has led to constant commodity stock outs and lack of methods of choice (Crichton, 2008). The Kenyan government has been slow in responding to the shifting international aid allocations, and in fact, it was only in 2005 that the government allocated 200 million Kenyan Shillings, or US\$2.62 million, for contraceptive commodities (ibid.). Obviously, the likelihood that a woman will seek to terminate an unintended pregnancy increases with unmet need 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 (Cohen, 2009). Access to reproductive health services and contraceptives has been worsened by the Global Gag Rule, also called the Mexico City Policy. It was implemented in 1984 and bars international organizations from using foreign aid to pay for any medical operation to end a pregnancy. The policy was reinstated by President Trump, who also expanded the policy to include money for global health assistance that went for HIV, maternal and other female reproductive services (Tong, 2017). The President defunded the U.N. Population Fund (UNFPA), the primary U.N. agency working to advance family planning and reproductive health around the world.

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).³ Under Sections 158,⁴ 159,⁵ and 160,⁶ 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 240,⁷ though, provided an exception by allowing for legal abortion to save a woman's life. However, the law did not go further to explain the circumstances in which lawful abortions could be provided, although there were expansive interpretations of this exception issued by the Ministry of Health and the Medical Practitioners and Dentists Board, allowing for abortions to be lawfully performed in cases of risk to the woman's health, or in some cases of rape (Center for Reproductive Rights, 2010). 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 (ibid.).

Although these restrictions on abortion existed, they failed to curb backstreet abortions, as evidenced by the figures presented above. Furthermore, the law was not being implemented, as prosecution of abortion providers, and of those who received them, was unusual in Kenya. This was despite the fact that newspapers often carried reports of discarded fetuses and of women dying after attempting to terminate their pregnancies. While the majority of women with unwanted pregnancies from the lower socio-economic stratum were forced to

³ This document is available at <http://www.kenyalaw.org/Downloads/GreyBook/8.%20The%20Penal%20Code.pdf>

⁴ "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)

⁵ "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)

⁶ "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)

⁷ "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)

seek abortions from those unqualified to perform such procedures, those from the higher socio-economic stratum could illegally secure safe abortions from trained physicians or travel to countries where it is legal. This resulted in further discrimination against poor and younger women, who could not afford the clandestine fees charged by doctors to terminate pregnancies. In fact, qualitative research on abortion in Kenya seldom mentioned fear of prosecution as a concern informing a woman's decision on how and where to have an abortion (Izugbara et al., 2009). Rather, most concerns were over the safety and expense of various methods and providers.

It is therefore not surprising that Kenya's Constitution 2010 expanded the circumstances under which legal abortion could be offered. As noted earlier, Kenya's Constitution, although recognising the right to life from conception, 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 new 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.⁸ 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.

As they stand, the above noted Constitutional provisions can secure women access to legal abortions in Kenya. It has however been found that expanding access to legal abortion does not in itself guarantee a decrease in unsafe procedures (Gutmacher Institute, 2012). Increasing safe abortion services following legal reform thus requires sustained commitment and dedicated human and financial resources. This is more so because although the new law has been in existence for close to seven years, unsafe abortion remains a leading cause of maternal morbidity and mortality. The treatment of complications of unsafe abortion also continues to consume significant health systems resources. This is despite the Ministry of Health having developed Standards and Guidelines for Reduction of Morbidity and Mortality from Unsafe Abortion in 2012 (ibid.).

In 2011, the Ministry of Health set up a working group to draft guidelines on abortion provision in line with the constitution. The guidelines 'Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion' were published in September 2012 and included up-to-date guidance from the 2012 WHO Safe Abortion Guidance.⁹ The guidelines were widely considered sufficient as they expressly provided for termination of pregnancy, provided that it is performed by a trained and skilled health professional within the confines of the law (ibid.).

In December 2013 however, the Ministry of Health withdrew the Standards and Guidelines with the argument that there was need for wider stakeholder consultation on some of the contents of the document.¹⁰ In the absence of clear guidance on the provision of abortion, safe abortion remains a dream for majority Kenyan women. This is despite of the legal and constitutional provisions discussed earlier.

The following section examines the opportunities that the legal and constitutional provisions offer in relation to access to legal safe abortions.

Opportunities for Legal Safe Abortion in the 2010 Kenya Constitution

Article 43(1)(a) of the Constitution affirms that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care." This provision not only explicitly elevates the provision of reproductive health to a human right that must be protected, but also places clear obligations upon the state to provide the services. Within the framework of the World Health Organization's (WHO) definition of health, reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (Programme of Action of the International Conference on Population and

⁸ The judiciary or Parliament could enact law expanding the conditions under which legal abortion could be offered.

⁹ <http://www.safeabortionwomensright.org/wp-content/uploads/2018/02/Standards-Guidelines-for-the-Reduction-of-Morbidity-and-Mortality-from-Unsafe-Abortion.pdf>

¹⁰ It should not be lost that at about that time, USAID, who fund much of Kenya's family planning provision, advised organizations receiving US aid not to attend government meetings intended to discuss the Standards and Guidelines.

Development, 1994). Seen this way, provision of reproductive healthcare and adequate family planning services, including safe abortion and post abortion care, form part of the health care services to which women are entitled rather than frigate benefits. For instance, according to the Ministry of Health National Post Abortion Care Curriculum:

Comprehensive [post-abortion care] is a life saving procedure that should be available to all women and provision of comprehensive postabortion care does not lead to punishment or withdrawal of registration of the service provider. The medical profession has the responsibility to provide comprehensive postabortion services including family planning to all women who need them.¹¹

Additionally, Article 43(2) provides that “A person shall not be denied emergency medical treatment.” This provision places a strong obligation on the state to ensure that all persons, including women seeking post-abortion care or emergency abortion services, receive necessary medical treatment. Research findings have in the past shown that some women have been denied treatment for lack of money or if they are suspected of having interfered with a pregnancy (Centre for Reproductive Rights, 2012). Thus the inability to pay for services, providers’ or institutions’ private objections to providing certain types of care, and stigma-related delays in care are unconstitutional grounds on which to deny abortion-related emergency treatment (Jayaweera et al., 2018). Research has shown that women turn to unsafe methods because of factors such as cost, fear of stigma, exposure, and legal repercussions (Gemzell-Danielsson, 2017). Recognizing such factors, the proposed Standards and Guidelines developed by the Ministry of Health require health professional who may have a moral or religious objection to abortion to refer eligible clients to colleagues who are willing to provide the services (Gathura, 2013).

As noted earlier, Art 26(4) of the 2010 Constitution specifies “*life or health*” as grounds for legal abortion, which greatly expands access to legal abortion beyond what existed in Penal Code Section 240. If the meaning of “health” in this clause is interpreted as widely as it is in America¹² or as defined by the WHO, Kenyan women are likely to access legal abortions for extended reasons. The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1992). Defined in this way, women are likely to access legal safe abortions if continued pregnancy endangers the physical and/or mental health of the pregnant woman. In New Zealand¹³ for example, although the law says that legal abortion can be offered after the approval of two specialist consultants, women have generally been able to access legal safe abortions.

Additionally, if the “trained health professionals” mandated to perform abortions is interpreted as including doctors, clinical officers, nurses, and midwives, safe abortions will be available to women in rural areas where doctors might not be available. Moreover, the clause “or if permitted by any other written law” makes clear that the grounds listed in Section 26 of the Constitution are the minimum conditions under which abortion should be legal. In addition to leaving open the possibility for Parliament or the judiciary to pass law to create additional conditions for legal abortion,¹⁴ the clause does not allow for any written law which could limit access to abortion.

Furthermore, because Article 2 (6) of the Constitution stipulates that any treaty or convention ratified by Kenya shall form part of the law, Kenyan courts should be instrumental in the implementation of international law at the domestic level. The judiciary is required to determine and interpret the provisions and

¹¹ Available at

http://www.google.co.ke/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCgQFjAA&url=http%3A%2F%2Fwww.postabortioncare.org%2Ftraining%2FMOHKen_National_Curriculum_Service_Providers.pdf&ei=uROCUqmxNKPS0QX-yIDoCQ&usq=AFQjCNGdD72Dk4b56FYENXjJdfvaMYahNg&bvm=bv.56146854,d.d2k

¹² During the 1973 rulings in *Doe v. Bolton*, the Court defined *health* to include not just physical health, but also psychological, mental and emotional health. The Court cited age, familial circumstances and anything relevant to the woman’s general feeling of well-being as reasons that would justify abortion.

¹³ In order to obtain a legal abortion in New Zealand, a woman must obtain the approval of two specialist consultants, and the consultants must agree that either (a) the pregnancy would seriously harm the life or the physical or mental health of the woman, (b) the pregnancy is the result of incest, (c) the woman is severely mentally handicapped, or (d) a foetal abnormality exists. An abortion will also be considered on the basis of the pregnant woman’s young age or when the pregnancy is the result of rape (Major et al., 2009, p. 871).

¹⁴ For example if a pregnancy is the result of rape or incest, as it is in Ethiopia (Gebreselassie et al., 2010).

implications of various international treaties and conventions, especially in instances where domestic provisions are pitted against international provisions. This is more so because the Constitution, under Article 20 (3), compels courts to adopt an interpretation (of the law) that most favours the enforcement of a fundamental right or freedom. For example, although Kenya ratified the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) on October 8, 2010, it entered a reservation on Article 14(2) (c), which obliges African states to take measures to ensure availability of abortion in situations of rape, incest and where the physical and mental health of the mother is at risk. Kenyan courts are thus expected to adopt the provisions of the Maputo Protocol, since they most favour Kenyan women's right to legal and safe abortion. Additionally, the Bill of Rights in the 2010 Constitution gives all persons the right to institute petitions in the High Court, and to have their rights recognized and enforced, either in their own individual capacity or on behalf of others. As such, any woman in Kenya is in a position to petition the High Court if she is denied legal abortion. This provision is enhanced by the fact that courts are mandated to listen to and to determine such petitions without due regard to technicalities of procedure and without any filing fees being charged.

Seemingly, the 2010 Constitution has addressed the issue of illegal abortion in Kenya. However, as demonstrated in the following section, liberal abortion law does not necessarily ensure the safety of abortions.

In fact, eight years after the inauguration of the Kenya Constitution, Kenyan women continue to be deprived of essential reproductive health services—including quality maternal health care and safe and legal abortion services. This is mainly because of a lack of clear guidelines to guide the implementation of the Constitutional provisions. As has been noted, restrictive abortion laws actually increase the incidence of unsafe abortions.

A 2017 World Health Organization report notes that the average rate of unsafe abortion is generally four times higher in countries with more restrictive abortion laws than in countries with less restrictive laws (Johnson et al., 2017). The report also notes that restrictive abortion laws are associated with higher levels of maternal mortality. It observes that, "the average maternal mortality ratio is three times higher in countries with more restrictive abortion laws (223 maternal deaths per 100 000 live births) compared to countries with less restrictive laws (77 maternal deaths per 100 000 live births)" (pp. 542).

In an attempt to ensure that the Kenya government provides guidance on implementing constitutional provisions on abortion, the Center for Reproductive Rights in 2015 filed a case against the Attorney General, the Ministry of Health and the Director of Medical Services. The case was filed on behalf of the Federation of Women Lawyers (FIDA) Kenya, two community human rights mobilizers, an adolescent rape survivor suffering from kidney failure and other health complications due to an unsafe abortion and on behalf of all Kenyan women of reproductive age.

Challenges to Implementing Abortion Provisions in the 2010 Constitution

One of the major challenges towards implementing abortion and reproductive health provisions in Kenya is related to the fact that religious organisations, which are generally opposed to abortion, control almost a third of health institutions in Kenya. There are 974 religious-based health facilities, 964 belonging to the Kenya Episcopal Conference (KEC) and the Christian Health Association of Kenya (CHAK), together providing 40 per cent of national health services (Mandi, 2006). To date, most church-controlled health centres do not provide contraceptives or abortion, even for needy cases. As such, it is unlikely that abortion services will be available to women in such hospitals. Considering that church-controlled hospitals are sometimes the only available healthcare providers in remote areas, women are likely to continue relying on unqualified people for abortion services – unless, of course, the Kenyan government provides these services.

At another level, religious organisations also have considerable influence in the education sector. At independence in 1963, 90 per cent of the schools in the country were connected to one or other of the churches.¹⁵ Although attempts were made after independence to make education relevant to the needs of the Kenyan society, the Ominde Commission of 1964 and the Education Act of 1968 both emphasized the importance of teaching Christian religious education in schools under the guidance of various churches which sponsored them (Ojiambo, 2009). Religious influence in the school curriculum is evident in the following excerpt from an official school text book:

Young people who procure abortion often end up leading depressed, frustrated, unwholesome and lonely lives which usher them into a further abyss of depravity and drug addiction.

A girl will always know and live with the reality that she wilfully smothered and killed her unborn child. It is fairly haunting and dauntingly prickly to one's conscience. Hallucinations, dementia and ultimate madness are the likely consequences for the victims. (Otiende et al., 2001, p. 26)

¹⁵ Kenya National Archives, Nairobi ES File. Education Statistics 1964-1966.

Unsurprisingly, a study conducted by Adaji et al. (2010) on the attitudes of Kenyan in-school adolescents on abortion and unwanted pregnancies showed that the attitudes of the respondents were largely conservative with a majority of participants disapproving of induced abortion for school girls with unwanted pregnancies. The negative attitude, which is in conflict with the high rates of abortion among in-school adolescents, can be a result of the pervasive influence of Christian teachings. Their negative view of abortion, as well as contraceptives, may be influencing young women's decisions to have secretive but unsafe abortions. Unfortunately, this will continue since churches continue to have substantive control over the schools that they sponsor. For example, in October 2017, the Catholic Church, leaders and parents in a Catholic girl's secondary school demanded the arrest of Marie Stopes workers who they accused of administering birth control measures to students (Mutua, 2017). Although the organization explained that they had only conducted reproductive health awareness to the girls as the world celebrated the day of the Girl Child, investigations are still ongoing.

An additional challenge is weak health system in the country. For instance, as long as women are required to pay for abortion and family planning services, unsafe abortions will continue to be a major problem because unsafe abortion disproportionately affects poor women. This problem is evidenced by the fact that unsafe abortion remains a concern in a country such as Zambia, where abortion law has been liberalised (Koster-Oyekan, 1998). In Zambia, despite the broad grounds under which the Termination of pregnancy Act of 1972 legalized abortion, safe abortion services are not widely available, forcing many women to seek unsafe abortions (Ngoma et al., 2017). Lack of adequate services and continued procedural barriers limit women's access to safe abortions in the country (Lithur, 2004). This does not, however, downplay the importance of the translation of law to policy as a necessary step towards reducing the rate of unsafe abortions in a country. Rather, it points to the need for political will and commitment to ensuring the availability of services. In Kenya, the situation is worsened by the fact that the President and the Deputy-President are themselves ardent and active Christians.

The Kenya government has failed to provide an environment for safe abortion in the country. A study carried out in Cambodia, Colombia, Ethiopia, Mexico City, Nepal and South Africa identified key factors that determine how successfully abortion policy reform is implemented. These include: creating strategic campaigns to raise awareness among women and providers that the law has changed and that abortion is legal under certain conditions, developing clinical and administrative guidelines to standardize service delivery, and taking steps to ensure that providers have the necessary training and supplies (Gutmacher Institute, 2012). All of these are lacking in the Kenya situation. The Kenyan state needs to provide adequate human and financial resources to reproductive health services, evaluate and attend to the training needs of the different medical personnel, provide education on reproductive health, and facilitate access to contraceptives. Additionally, the state needs to revise the Kenyan Penal Code to reflect the language of the new abortion law, as the threat of legal consequences may, and actually has made health professionals reluctant to perform abortions. In 2014 for example, a nurse, Jackson Namunya Tali, was accused of performing abortion and was charged with aggravated murder under Sections 203 and 204 of the Penal Code of Kenya. The judge sentenced him to death (Finden, 2017; Makana, 2014).

Another challenge is lack of awareness to the change in abortion law. In the past, lack of awareness of the law has led to the false belief that abortion is illegal under any circumstances. Research carried out by Mitchell et al. (2006) reported that most young people in Kenya were under the false impression that the law prohibits abortion entirely. In their study population, almost a third of students believed, incorrectly, that abortion was never permitted in Kenya, and another 14 per cent reported that they did not know whether it was ever legal or not. As such, there is need for creating strategic campaigns to raise awareness among women and providers that the law has changed and that abortion is legal under certain conditions.

In 2010 Kenya ratified the Maputo Protocol, which, in Article 14(2C) calls on States Parties to "take all appropriate measures to 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 life of the mother or the foetus".¹⁶ This should have opened the door to law reform on these grounds. Unfortunately, Kenya put reservations on Article 14(2C) and therefore does not need to comply with it.

Clearly, successful implementation of the abortion law is likely to be a long process. Because abortion had been criminalized for a lengthy period of time, social change will be a necessary part of this process as people need to reconstruct their views on abortion. When the procedure is finally accepted, changes will become visible. In South Africa for example, the liberalisation of abortion laws in 1996 reduced the incidence of infection resulting from abortion by 52 per cent and that of maternal mortality by 92 per cent. This pattern has been repeated in Turkey where, since the passage of a law legalising abortion, maternal mortality due to unsafe

¹⁶ http://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf

abortion almost disappeared, and the burden of unsafe abortion on the health care system greatly decreased (Shah & Ahman, 2009).

II. CONCLUSION

It has been found that expanding access to legal abortion does not in itself guarantee a decrease in unsafe procedures (Guttmacher Institute, 2012). However, as shown in this paper, increasing safe abortion services following legal reform requires sustained commitment and dedicated human and financial resources. Legal reforms are needed to align the penal code provisions on abortion to the Constitution and Kenya's international human rights obligations by making abortion legal.

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