

Briefing Paper

Women, Reproduction and the State in Kenya



Kenya National Commission on Human Rights

July 2009

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Preface

This briefing paper is a synthesis of a half-day discussion on reproductive health rights in Kenya that was convened by the Kenya National Commission on Human Rights (KNCHR) on June 3rd, 2009. The discussion brought together 24 participants drawn from government agencies, the medical and health sectors as well as the human rights and governance sectors.

Concerned that the local debate on reproductive health rights appears to have stagnated, the KNCHR invited five expert presentations aimed at innovating new ideas and strategies to open new ground in this crucial national debate. KNCHR commissioners Winnie Lichuma and Anne Ngugi focused on contemporary reproductive healthcare concerns and debates in Kenya. Hilary Muthui presented an analysis of the pending Reproductive Health Bill 2008, while Dr. Margaret Meme concentrated on the medical aspects of reproductive health. Professor Lynn Thomas' presentation helped to contextualize the discussions by providing an overview of the history and politics of reproductive health in Kenya right from the colonial era and on into the 21st century.

This briefing paper integrates the five presentations with the ensuing discussions held by the broader group of participants. In so doing, it explores a number of questions that are pertinent to the nature of the debate on reproductive health rights in Kenya: What are the key reproductive health rights concerns in Kenya? What are the gaps and challenges? What is the status of the debate on reproductive health rights? What if any are the different sectoral interests pulling apart and preventing the discussion from moving on to the next level? What can human rights actors, medical and healthcare professionals and government agencies do differently?

The KNCHR wishes to thank the presenters and participants for their enthusiastic engagement with the subject. Special thanks to commissioners Wambui Kimathi and Anne Ngugi as well as Dr. Mutuma Ruteere of Adili Consulting Group for ably steering the discussions. Special thanks also to Collins Omondi for rapporteuring the meeting.

This briefing paper was written by Mikewa Ogada, a partner at Adili Consulting Group. Much thanks to Commissioner Wambui Kimathi and Cynthia Mugo of the Kenya Human Rights Commission (KHRC) for their critical editorial inputs.

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Background

With the spread of the ideas of democracy and human rights, many societies and governments are beginning to realize that legal prohibitions on reproductive health (RH) options tend to endanger women's lives. Even though RH issues remain among the most controversial in international human rights law, more and more governments are acknowledging the need to expand women's and men's access to RH services as fundamental to improving their lives.

This affirmation appears in the resolutions of the 1994 Beijing World Conference on Women that addresses reproductive rights as well as the Millennium Development Goals (MDGs), which call on governments to intensify efforts to increase their citizens' access to RH services.¹ Additionally, a variety of international human rights instruments, among them the Convention on the Elimination of Discrimination Against Women (CEDAW), safeguard women's rights over their RH choices.² Indeed, in 2003 the United Nations (UN) Commission on Human Rights confirmed that RH is an integral element of the right of each person to enjoy the highest attainable standard of physical and mental health.³

However, the most momentous declarations on RH so far made by the world's states occurred at the International Conference on Populations and Development (ICPD) which was held in Cairo, Egypt in 1994. Under the ICPD Programme of Action, a general consensus was reached that both women and men ought to be able to enjoy satisfying and safe sex lives as much as they should also enjoy the freedom to decide if, when and how often to have children.⁴ For this rhetorical consensus to make any sense, women and men ought to be empowered to make informed choices in relation to their sexual and reproductive lives. In addition, women and men must have access to safe, effective, affordable and acceptable reproductive healthcare services.

Evidently, the ICPD was a landmark event which produced a conceptual leap in the way population and RH problems are defined and understood. Key actors concerned with RH now recognize that it is fundamental to individuals, couples and families as well as the socio-economic development of communities and nations. Because of this seminal conference, RH is today viewed more expansively, beyond the narrow confines of family planning programmes for instance. Moreover, the needs of women are today receiving much more attention in the different available RH approaches. Equally important, various actors in the field of RH are increasingly

¹ Five of the eight MDGs focus on maternal health, child health and HIV/AIDS, gender equality and poverty, which all relate directly to RH.

² Other key international instruments with a bearing on reproductive health are: the Universal Declaration on Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic and Social Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of Racial Discrimination (CERD), the Convention Against Torture (CAT), the Rome Statute of the International Criminal Court (ICC), the Vienna Declaration and Programme of Action on Human Rights and the Beijing Platform of Action.

³ It should be clarified that the Commission was replaced by the Human Rights Council in 2006.

⁴ The ICPD defined reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system". RH rights on the other hand were defined as "the constellation of methods, techniques and services that contribute to reproductive and sexual health and well-being by preventing and solving reproductive and sexual health problems".

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accepting and asserting the importance of the idea of human rights in the promotion of RH for all people.

Shortly after the conference, the Kenyan Government initiated a process aimed at domesticating the ICPD Programme of Action in its broader national health strategy.⁵ In 1996 for example, the National Reproductive Health Strategy (1997-2010) was launched, while the Sessional Paper on the National Population Policy for Sustainable Development was approved by parliament in 2000. The core objective of the strategy is the:

"Provision of a comprehensive and integrated system of reproductive health care, that offers a full range of services by the government, non-governmental organizations (NGOs) and the private sector as outlined by the National Population Policy for Sustainable Development and the Kenya Health Policy Framework of 1994".

The strategy's main components include family planning and safe motherhood and child survival initiatives; promotion of adolescent and youth health; gender and reproductive rights; and HIV/AIDS management. Other supporting health frameworks include the 2008 National Health Sector Strategic Plan; the National Reproductive Health Implementation Plan 1999-2003; the HIV/AIDS Strategic Plan 2001-2005; and the 1997 Reproductive Health and Family Planning and Standards for Service Providers.

Arguably, the Kenyan Government has taken important strides to improve access to RH care. Yet it can still do more to expand RH services to reach more women and men. As a matter of fact, the coverage of RH care could be significantly enhanced if RH services were made more affordable, efficient and adequate to meet the needs of women, men and the youth. Improved RH care has many other benefits. Better RH care is likely to reduce maternal and child mortality rates in addition to accelerating progress towards attainment of MDGs generally. Deeper penetration of RH care is also likely to equalize and improve gender relations. Furthermore, adopting a rights-based perspective to RH issues stands to empower more and more people to claim their RH rights and make smarter choices over their sexual and reproductive lives.

Key Reproductive Health Issues in Kenya: Gaps and Challenges

Anecdotal evidence suggests that many Kenyans, the vast majority of them being poor women and men; do not have sufficient access to quality RH care. Even though progress has been made in the containment of fertility and population growth rates, maternal mortality rates have increased from 395 to 414 per 100,000 births in the period 1989-2003.⁶ Regrettably, child mortality rates have also risen from 62 to 78 per 100,000 births in the same period, while the

⁵ Thumbi, Peter, *Kenya Country Report on Reproductive Health and Reproductive Rights*. National Coordinating Agency for Population and Development (2002).

See: http://www.uneca.org/eca_resources/Major_ECA_Websites/icpd/fourth/Kenya.htm.

⁶ See National Coordinating for Population and Development (NACPD) and ORC Macro, 2006 *Kenya Service Provision Survey 2004 Maternal Health Findings*, Nairobi Kenya: 2. Quoted from Muli, Elizabeth, "Do they Exist? Women's Reproductive Health Rights in Kenya. *The Law Society of Kenya Journal*, 4(1) 2008: 66-67. Recent data is unavailable pending the release of the results of the 2009 National Population Census.

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number of women receiving medical assistance during delivery has declined from 50 to 42 percent.⁷

Contraceptives, including ‘the pill’, emergency contraceptives and the male condom, are available in 85 percent of institutions offering family planning services yet they remain unaffordable to most Kenyans, nearly half of whom live in poverty.⁸ However, longer-term and permanent contraceptive methods, such as Intra-Uterine Devices (IUDs), are less accessible as only 36 percent of institutions offering family planning services provide them.⁹ About sixty-five (65) percent of these facilities offer female sterilization procedures in contrast to only two percent for men. So far, 53 percent of all contraceptives are supplied by government and private health institutions bridge the gap. Generally, women around the country have to travel long distances to get RH care from a public health system which has insufficient numbers of properly trained personnel.¹⁰

Many factors combine to account for the inadequacy of Kenya’s RH care system. For a start, the country’s health infrastructure remains largely under-developed even though some important measures have been taken in recent years to improve it.¹¹ For instance, there is no up-to-date, reliable data set on RH issues, neither is there an adequate data-gathering mechanism. While the Ministry of Health and International Federation of Women Lawyers-Kenya Chapter (FIDA-Kenya) commissioned a study in 2004 to evaluate the extent of RH rights violations, it is yet to be updated to reflect current trends. More generally, the government-coordinated Kenya Demographic Health Survey (KDHS) provides data on maternity yet it does not sufficiently explain why the trends. There is also the challenge of generating and allocating more resources to ensure that RH care reaches more people, especially younger adults and adolescents.

The criminalization of abortion, sexual and gender-based violence (SGBV) targeting women, poverty, patriarchy and religious conservatism also combine to impede the realization of RH rights. In particular, while section 240 of the Penal Code gives the mistaken impression that abortion is illegal under all circumstances, section 228 provides that it is justifiable when performed to save a woman’s life.¹² In general however, Kenyan law fails to specify the precise set of circumstances and conditions under which it is lawful to perform an abortion.¹³ While it would be desirable to use the courts to challenge the country’s deficient legal framework on abortion, the inherent deficiencies and perceived conservatism of the judicial system do not make

⁷ Ibid., 67.

⁸ In its *2008-2012 First Medium Term Plan*, published in 2008, the Ministry of State for Planning, National Development and Vision 2030 points out that about 46 percent of Kenyans live below the poverty line.

⁹ See *Kenya Demographic and Health Survey 2003*. Quoted from E. Muli at page 75.

¹⁰ Ibid., 74.

¹¹ Kenya allocates just about eight percent of its national budget to healthcare, far below the 15 percent threshold agreed by African Union leaders under the Abuja Declaration of 2001. Since 2008 however, the Ministry of Medical Services and the Ministry of Public Health have launched several initiatives aimed at expanding the health sector. One such initiative is the building of seven referral hospitals in seven of the country’s eight provinces.

¹² The Kenyan Penal Code does not equate abortion with murder but the procedure is associated with the apparently lesser crime of infanticide which is quite distinct from murder. The Penal Code also outlaws the supply of equipment specifically designed for carrying out abortions.

¹³ Other legal provisions with a restrictive effect on RH include sections 158 and 159 of the Penal Code and sections 38 and 22 of the Pharmacy and Poisons Act.

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it a particularly appealing mechanism for the adjudication of RH rights issues such as the right of women to freely procure abortions.

All the same, many poor women seeking to terminate unwanted pregnancies are compelled to procure unsafe abortions in clandestine, ill-equipped clinics. It is estimated that about 250,000 illegal abortions were performed each year in Kenya during the 1980s and 1990s on women generally aged 25 years or below.¹⁴ In the absence of a clear policy framework on abortion however, it should not come as a surprise that out of the 6,000 maternal deaths recorded annually, 2,000 are attributed to abortion-related complications.¹⁵ In fact, the largest referral hospital, Kenyatta National Hospital (KNH), deals daily with about 100 women and girls suffering from the effects of botched abortions. It seems this trend has its roots in the past two decades in which it is estimated that 60 percent of all gynaecological admissions resulted from botched abortions which killed 1,000 to 5,000 Kenyan women and girls each year.¹⁶

Limitations and weaknesses in Kenya's RH care system can be partly explained by the country's deeply ambivalent "politics of the womb."¹⁷ During the Kenyatta and Moi presidencies, this apparent ambivalence grew from the two leaders' need to appease their national and international constituencies. At one level, they sought to demonstrate that even though they were committed to undertaking RH reforms they were not stooges of a foreign-driven RH campaign. On another, they were hard pressed not to trample on male constructed "African values" which falsely asserted that availing birth control to unmarried women would turn them towards the vices of promiscuity and prostitution. The tensions created by the need to stay poised amidst the diverging interests of their constituencies "resulted in ambivalent approaches in which different constituencies – ranging from the *wananchi* to international donors – received different messages and in which public pronouncements [on RH] frequently did not match policy implementation."¹⁸

Locked in Between the Past and the Present? The Debate on Reproductive Health

Public debate on reproductive health in Kenya has its roots in Kenya's colonial past. In 1955, the East African Royal Commission (EARC), a body appointed by the colonial government to review socio-economic development, concluded that there was no need for a birth control programme in Kenya because overpopulation was not yet a problem in the country. Instead, the EARC argued in its report that a higher population would be better for economic growth.

¹⁴ Thomas, Lynn, "Politics of the Womb and Postcolonial Ambivalence in Kenya", Paper presented at Historical Association of Kenya Conference, "Post Colonial Kenya: The First Forty Years," 10-14 June 2004: 17.

¹⁵Data provided by expert presenter with medical background. At the global level, the Centre for Reproductive Rights (CRR) estimates that some 70 million women have unwanted children each year which place unwarranted strains on their health, family relationships and economic resources. About 20 million more have unsafe abortions each year resulting in some 70,000 deaths per year. For critical resources on reproductive health rights, please consult www.reproductiverights.org.

¹⁶ L. Thomas at page 17.

¹⁷See L. Thomas generally for an incisive discussion of the idea of the "politics of the womb" as it relates to RH in Kenya.

¹⁸Ibid., 1.

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Only five years after Kenya won its independence, the government fell under international pressure to stem its population growth, which was cast as a deterrent to the country's development.¹⁹ As pointed out earlier, the government of President Jomo Kenyatta sought to appease the demands of international donors yet his government's family planning efforts did not reverse the population growth rate. Critical of this apparent failure, some observers claimed that his government simply "lacked the political will to convince its citizenry that national prosperity depended upon lowering population growth."²⁰ Other politicians propounded a more sinister view, arguing that the foreign-driven RH reform agenda was actually a genocidal conspiracy, presumably aimed at placing a cap on the population of Africans.

When by the early 1980s Kenya recorded one of the highest population growth rates worldwide - 3.8 percent- in the context of a contracting national economy, President Daniel arap Moi's government moved to assure international donors of its commitment to RH reform by massively expanding the available RH infrastructure. Besides establishing a national council on family planning that essentially urged families to limit their sizes to three or so children, the number of health workers trained in family planning methods doubled to more than 2,000 as distribution centres for contraceptives quadrupled to 400.²¹

While the controversy surrounding family planning has since dissipated from its highpoints in the 1960s and 1970s, the abortion debate however remains highly contentious. Indeed, it appears contemporary debate on RH is stuck on whether or not abortion should be legalized. Differences of opinion on the issue have been reflected in various draft constitutions, with both the 2005 and 2009 drafts expressly prohibited abortion except in cases where a woman's life would be endangered if she were to carry a pregnancy to term.²² While the 2005 draft prohibited abortion in principle, it left open the possibility for Parliament to develop legislation that could expand the lawful grounds for the procedure.²³

Divergent interests and approaches, including the more liberal stances of human rights groups, professional medical and health associations and policy makers as well as the conservatism of religious organizations, continue to complicate the abortion debate. In particular, research suggests that the Kenyan state's position on abortion is "complex and often contradictory."²⁴ Even though thousands of abortions are performed annually, hardly any receive official authorization and prosecutions of procurers and providers alike are quite rare. As a result, through its failure to enforce its own laws on abortion, the Kenyan state "situates itself as a defender of sexual morality and pro-natalist ideals while relegating abortion to an unregulated realm where money largely determines who has access to safe abortions and who does not."²⁵ Today, the dissonance in government is even more apparent with different public positions, some in support of the procedure and others not, having been taken by cabinet ministers.

¹⁹ Among the key expatriate advisors and international donors were the US-based Population Council and the Ford Foundation. These international actors advocated for a national maternal and child healthcare system that availed free contraceptives, including birth control pills and IUDs. See L. Thomas at page 4.

²⁰ *Ibid.*, 4-5.

²¹ *Ibid.*, 5-6.

²² See Part II, section 34(3) of the Draft Constitution of Kenya 2004.

²³ See Ghai, Yash Pal, *East African Standard* of October 26, 2005.

²⁴ L. Thomas at page 18.

²⁵ *Ibid.*, 19.

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This ambivalence seems to trickle down to influence citizens' imagination on abortion. In fact, a study conducted in Western Kenya found that while many people did not support the legalization of abortion, they were prepared to recommend the procedure to a friend carrying an unwanted pregnancy. The very same respondents argued however that liberalizing abortion would lead to immorality and promiscuity. It seems then that what there is in Kenya is not a fear of the law on abortion per se but perhaps a fear of law enforcement agencies.²⁶ Possibly fearful of the law however, some RH actors have been criticized for failing to address the abortion question head on, preferring instead to confine their attention to less controversial RH issues such as post-abortion care.

Then again, their strategy of focusing on less controversial RH issues may be borne of the realization that a confluence of factors makes the obstacles to legal reforms insurmountable in the foreseeable future. Consequently, they have chosen to address less culturally sensitive issues such as post-abortion care, increasing public knowledge on Kenya's legal framework on abortion, and training health workers to provide "high quality termination of pregnancy services."²⁷ Basically, it appears that these RH actors are exploiting "the state's ambivalent stance towards abortion by encouraging a liberal interpretation of the existing law to focus on what happens when incomplete abortion cases arrive at hospitals."²⁸

In general, either the deliberate or inadvertent focus of the RH debate on abortion can be said to be partly responsible for the lack of a breakthrough in new, innovative thinking on the debate on RH care in Kenya. Partly because of the seeming prevalence of widespread conservative views on abortion, the proposed Reproductive Health Bill 2008, which expands the grounds that allow women to elect to undergo the procedure, has generally been received negatively by Kenyans and legislators.²⁹ This state of affairs is regrettable however as the bill contains some progressive, non-abortion related RH provisions that have not gotten sufficient public and parliamentary attention.³⁰ Might it be therefore that the bill's proponents are not paying adequate attention to the nature and timing of their lobbying for the bill's passage and enactment? How might have the kind of language and profiling used to campaign for the bill's passage branded it amongst Kenya's largely conservative societies?

²⁶ To put this statement in context, one needs to consider the argument that Kenya's legal framework, particular its criminal law (and the institutions of enforcement), has historical enjoyed little popular legitimacy.

²⁷ Funders of research on the application of research on these approaches in Kenya include the Rockefeller Foundation, the United Nations Agency for International Development (USAID) and the Population Council, working with the Ministry of Health, local non-governmental organizations (NGOs) including the Centre for the Study of Adolescence and the Family Planning Association of Kenya. See L. Thomas at page 21.

²⁸ *Ibid.*, 21.

²⁹ It should be noted that in contrast to South Africa's Termination of Pregnancy Act and legislation from most Western countries, the proposed Reproductive Health Bill 2008 does not allow abortions to be procured without restriction or reason. Among the grounds provided in Part IV of the draft law are (a) the continued pregnancy would pose a risk of injury to the woman's physical or mental health (b) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality (c) the pregnancy is the result of rape or incest and (d) the pregnant woman is not mentally sound.

³⁰ The bill proposes, *inter alia*, to expand access to contraceptives and RH care generally to women, expectant mothers affected by HIV/AIDs and adolescents.

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It has been suggested that surmounting these kinds of obstacles, which stand in the way of RH legislation, calls for a long-overdue paradigm shift in thinking around RH issues. Because some 4,000 women die annually from non-abortion related birth complications, should not the focus of actors working in the RH field shift from the controversy over the legalization of abortion to the problem of maternal mortality? Has comparable energy been expended debating and publicizing the deaths of mothers who die from these kinds of birth complications?³¹ Proponents of this paradigm shift argue that actors in the RH field ought to lobby for sufficient resources to be availed in order to prevent such deaths which have, for some, turned pregnancy into a death sentence. Undoubtedly, the Reproductive Health Bill 2008 contains several important provisions that theoretically stand to reduce the incidence of maternal mortality in the country. Could it not then be branded as the Maternal Healthcare Bill to better capture the imagination and support of parliamentarians, a significant cross section of which is sceptical about the Reproductive Health Bill that is perceived as a law that legalizes abortion?

To move the debate on RH forward, human rights actors in particular need to think about deemphasizing their legalistic outlook and balancing it with a much more nuanced cultural perspective. Proponents of this approach argue that developing diverse ethnographic understandings of pregnancy from the time of conception till birth stands to enrich the RH debate and make it more palatable to a larger number of Kenyans. Part of their reasoning rests on the controversial assumption that so-called “African values” have a stronger sway in African societies as compared to Western legalistic notions. Several criticisms are offered however to this approach, one of them being that “African values” on issues like abortion are likely to be disconnected from the prevailing reality. Depending on their outcomes, opponents of ethnographic analyses of RH issues argue that they may be interpreted as being aimed at stigmatizing particular communities. There is also the risk of falling into the trap of cultural relativism.

Human rights actors must also accept that they sometimes are most audible about issues such as RH of which they do not have much expert knowledge. They can therefore expect to “turn off” other actors who are likely to resist their attempts to steward a debate with whose details they do not appear to have an intimate familiarity.

Another challenge facing the RH debate is its narrow focus on heterosexual reproductive sex to the exclusion of other issues. Indeed, Kenya’s reproductive health rights framework is glaringly silent on questions of non-procreative sexual activity, the rights of sexual and gender minorities and sex workers as well as sexuality as it relates to children and the elderly. This somewhat unsophisticated approach to the complex idea of sexuality risks eclipsing a number of sexual rights issues that are critical to the realization of reproductive health rights for all. Human rights groups and their strategic partners therefore have to surmount the challenge of bringing in new perspectives to the reproductive health rights debate in order to promote the broadest possible conception of the ideas of sexual and reproductive health rights.

³¹ Maternal death is described as the death of a woman during pregnancy, at birth or up to 42 hours after birth. It will be recalled that maternal mortality rates have increased from 395 to 414 per 100,000 births in the period 1989-2003.

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In general however, there are several important opportunities available to human rights actors to advance the debate on RH rights. There is growing support for concepts such as safe motherhood as well as the use of emergency contraception. Thus far, human rights actors and media practitioners have been reflecting on RH issues for sometime now under the framework of the Reproductive Health Rights Alliance (RHRA). Professional healthcare associations, such as the Kenya Medical Association are also displaying more willingness to engage in the RH debate. Although some religious groups continue to hold conservative views about RH rights as stated earlier, there are those which have now adopted much more open-minded perspectives.

Refocusing the Debate on Reproductive Health: Some Recommendations

On the basis of the foregoing analyses, this brief makes the following recommendations:

To human rights actors and civil society groups generally:

1. Build strategic alliances with key actors in the RH field, paying particular attention to policy makers (government technocrats and legislators) as well as religious leaders;
2. Pre-test RH campaign messages before using them publicly to ensure that the language and branding of RH issues is acceptable to the public;
3. Develop advocacy and outreach strategies on solid, knowledge-based platforms to heighten credibility of public statements and interventions;
4. Build a high level of internal consensus within the human rights, governance and development sectors on a broad range of RH issues, including abortion;
5. Develop strategies aimed at building and sustaining the momentum of the debate on RH;
6. Convene a broad-based reflection to debate the need for a paradigm shift in thinking around RH issues that emphasizes non-abortion related birth complications such as maternal mortality;
7. Determine ways of deemphasizing the legalistic nature of the RH debate and RH rights campaigns in order to bring in much more nuanced cultural perspectives;
8. Commission research into beliefs and practices centring on the ideas of pregnancy and abortion as they are manifested in Kenya's different ethnic communities;
9. Reflect on ways of making men a key focus of both the debate on RH rights as well as RH care policies and programmes;

To the relevant institutions of the Kenyan Government:

1. Consider adopting the Human Rights-Based Approach (HRBA) to planning for RH;
2. Improve government-conducted surveys, such as the Kenya Demographic Health Survey, to provide much more nuanced analysis by expanding the scope of survey questions to enable both exposition and explanation;
3. Build strategic alliances with civil society actors generally to take advantage of their unique capacities and resources so as to push the RH agenda forward;
4. Reflect on ways of making men a key focus of RH care policies and programmes;

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ANNEX 1: LIST OF PARTICIPANTS, KNCHR OFFICES, 3 JUNE 2009		
Name	Organization	Phone & Email
Fatuma Dullo	Kenya National Commission on Human Rights (KNCHR)	fdullo@knchr.org
Wambui Kimathi	Kenya National Commission on Human Rights (KNCHR)	wkimathi@knchr.org
Winnie Lichuma	Kenya National Commission on Human Rights (KNCHR)	wlichuma@knchr.org
Anne Ngugi	Kenya National Commission on Human Rights (KNCHR)	angugi@knchr.org
Mutuma Ruteere	Adili Consulting Group	+254-720-705051 mruteere@adiliconsult.com
Mikewa Ogada	Adili Consulting Group	+254-725-657597 mogada@adiliconsult.com
Kepta Ombati	Akiba Uhaki Foundation	0722-570490 kombati@akibauhaki.org
Grace Mukuhi	Bar-hostess Empowerment and Support Programmed	+254-722-520833 barhostess@yahoo.com
Mary Njeri	Coalition of Violence Women (COVAW)	+254-3874358 marynjeri@covaw.or.ke
Hilary Muthui	International Federation of Women Lawyers – Kenya (FIDA-Kenya)	+254-3870444 hilary@fidakenya.org
Joyce M. Majiwa	Independent Consultant	jmmajiwa@jambo.co.ke
Margaret Meme	Ministry of Health	-
Andrew Suleh	Kenya Medical Association (KMA)	sulehaj@yahoo.com
Esther Mungai	Nairobi Women’s Hospital	+254-727-736333 emungai@nwch.co.ke
Karugu Ngatia	National Coordinating Agency for Population and Development (NCAPD)	+254-711600/1 kngatia@ncapd-ke.org
Joyce Kimaso	Planned Parenthood Federation of America (PPFA)	+254-722-844827 joyce.kimaso@ppfa.or.ke
Alisha Bjerregaard	Reproductive Health Rights Alliance & Centre for Reproductive Rights	+254-735-244012 abjerregaard@reprorights.org
Judy Bolanle	Reproductive Health Rights Alliance	+254-2727049-52 judybolanle@ppfa.or.ke
Sheikh Hassan Omari	Supreme Council of Kenya Muslims (SUPKEM)	+254-722-375611 hssnomari@yahoo.com
Lillian Adongo	Tomorrow’s Child Initiative (TCI)	+254-2304776 info@tcinitiative.org
Mary Oyieko	Tomorrow’s Child Initiative (TCI)	+254-2304776 info@tcinitiative.org
Queen Katembu	United Nations Population Fund (UNFPA)	faith.katembu@undp.org
Owuor Olunga	University of Nairobi	owourolungah@uonbi.ac.ke
Lynn Thomas	University of Washington at Seattle	lynnmt@u.washington.edu

ANNEX 2

CATEGORIES OF ABORTION LAWS IN AFRICA FROM MOST-TO-LEAST RESTRICTIVE (SOURCE: CENTRE FOR REPRODUCTIVE RIGHTS, JULY 2007)

To save woman's life or prohibited altogether	To preserve physical health	To preserve mental health	Socio-economic grounds	Without restriction as to reason
Angola	Benin	Algeria	Zambia	Cape Verde
Central African Republic	Burkina Faso	Botswana		South Africa
Congo	Burundi	The Gambia		
Côte d'Ivoire	Cameroon	Ghana		
Democratic Republic of Congo	Chad	Liberia		
Egypt	Comoros	Namibia		
Gabon	Djibouti	Seychelles		
Guinea Bissau	Equatorial Guinea	Sierra Leone		
Kenya	Eritrea	Swaziland		
Lesotho	Ethiopia			
Malawi	Guinea			
Mauritania	Morocco			
Mauritius	Mozambique			
Niger	Rwanda			
Nigeria	Togo			
Somalia	Zimbabwe			
Sudan				
Tanzania				
Uganda				