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From Reproductive Rights to Sexual Rights: Contesting Abortion Politics in Kenya, 1963-2015

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Abstract
The abortion debate in Kenya has been a contentious issue for decades, with the recent lifting of a ban on Marie Stopes, a global charity offering abortion services, highlighting its urgency. This paper examines how transnational advocacy and local narratives have shaped the discourse around legalizing safe abortion in Kenya. It explores the historical trajectory of this struggle, from the post-independence period to international milestones such as the 1975 International Decade for Women, the International Conference on Population and Development (ICPD) in Cairo, the Beijing *Plus 5* conference, and the Maputo Protocol. The analysis underscores the role of foreign influence, particularly from Britain, the USA, and Scandinavian nations, in introducing new models of sexual governance and nationalism. By employing a multidisciplinary approach, this study investigates how abortion discourses have been constructed, contested, and transformed, navigating the tensions between tradition and modernity. The findings argue that external advocacy and local efforts have been pivotal in advancing human rights, democracy, and the rule of law in Kenya.

Keywords: Abortion politics, gender, Kenya, reproductive rights, sexual rights

Introduction

By the turn of the Twentieth Century, almost every nation classified abortion as a felony, with a few Western countries including limited exceptions for medical emergencies and cases of rape and incest. Nevertheless, the commonality of abortions did not become a hotly contested political issue until the inception of the women's liberation movement and the sexual revolution of the 1960s and 1970s. These movements brought about renewed interest in public discussions about reproductive rights, family planning, and access to legal and safe abortion services (Klugman, 2000)

In 1962, the story of Sherri Finkbine, the local Phoenix, Arizona host of the children's programme, 'Romper Room' became national news. Finkbine, who had four children, had taken a drug, thalidomide, before she realized she was pregnant with her fifth child. Worried that the drug could cause severe birth defects, she tried to get an abortion in her home state, Arizona, but could not. She then travelled to Sweden for a legal abortion. Finkbine's story is credited with helping to shift public opinion on abortion and was central to a growing national and international call for abortion reform laws (Campbell, 1999).

In 1967, Colorado became the first state in the US to legalize abortion in cases of rape, incest, or if the pregnancy would cause permanent physical disability to the birth parent. By the time 'Maude's Dilemma' aired, abortion was legal under specific circumstances in twenty US states, and a rapid growth in the number of pro- and anti-abortion organizations had occurred in the 1960s and 1970s (Steans & Ahmadi, 2005).

The 1990s ushered in a new era in Africa. The Cold War was ending, and it significantly altered not only the African political landscape but also monumental social and economic

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structures. Monumental, not only because of the drastic restructuring of social, economic, and political spaces but also because of the introduction of new forms of social and political actors (Miyoshi, 2000). These changes were driven greatly by the developments in the global system, particularly the demise of the Soviet Union as a nation and superpower, the triumph of the market, and, more importantly, the end of the Cold War. The latter eliminated traditional Cold War-inspired support by the West and Soviet Block of the authoritarian leaders whose excesses were accommodated at the expense of the populace (Olukoshi, 1998). Such developments accompanied the liberalisation of the African economies, free movements of people and ideas, and opening of new markets for Western commodities ensured and, as such, fast altering the social sphere in which the youth were to be trapped for the next two decades (Smerdon, 2008).

Behind this global praxis was the growing internationalisation of sexual rights and identities, the women's movement, and increasing demands for basic equality, just as it lies behind the escalation of effective new sexual orientation in many urban areas of Africa. Kenya's growing commercial sector and its public have embraced global changes, reaching the pinnacle of capitalism today. It has become a preserve or marketplace of sexual information, enticing eager audiences with expert ratio programmes, newspaper gossip columns, and foreign romance novels. Western pornographic films and the expansion of the sexual marketplace serve to codify the category of youth further as development agents and commercial advertisements seek to appeal to and shape their young audience (Ginsburg, 1995).

Western Discourse and Abortion Debate

Since the 1990s, governments, International NGOs, and transnational coalitions have been the central advocates and implementers of the politics of reproduction and, to a somewhat lesser degree, of sexual health and rights (United Nations, 1994). Such nations and movements had begun to mobilize in their own ways and out of their own situations around reproductive health and rights issues, and a framework firmly linking these issues to both development issues and human rights emerged (Silman, 1997).

Whether positively or negatively, western countries have had a greater impact on abortion policies in African countries. For instance, decisions about the allocation of global health resources from the USA, which is the world's largest donor of development assistance in absolute terms, are closely linked to domestic abortion politics. First announced in Mexico City by the Reagan administration at the International Conference on Population in Cairo, the policy required all non-governmental organizations operating abroad to refrain from performing or counselling women about abortion as a strict prerequisite for receiving US federal funding (Cornwall, 2005).

A turning point in international discussions on population was the 1994 International Conference on Population and Development (ICPD) held in Cairo. Whereas earlier world conferences on population had focused on controlling population growth in developing countries mainly through family planning, the Cairo conference enlarged the scope of policy discussions. Governments now agree that population policies should address social development beyond family planning, especially the advancement of women, and that family planning should be provided as part of a broader package of reproductive health care. Underlying this new emphasis was a belief that enhancing individual health and rights would ultimately lower fertility and slow population growth. The Cairo conference was also far larger and more inclusive than earlier world population conferences (Cornwall, p. 34). It brought together 11,000 representatives from governments, nongovernmental organizations (NGOs), international agencies, and citizen activists. The diversity of views contributed to the unprecedented international consensus achieved in 1994 (Corrêa & Petchesky, 1994).

During and after the ICPD, some interested parties attempted to interpret the term 'reproductive health' in the sense that it implies abortion as a means of family planning or,

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indeed, a right to abortion. These interpretations, however, did not reflect the consensus reached at the Conference. For the European Union, where legislation on abortion was less restrictive than elsewhere, the Council Presidency clearly stated that the Council's commitment to promoting 'reproductive health' did not include the promotion of abortion. With regard to the US, only a few days prior to the Cairo Conference, the head of the US delegation, Vice President Al Gore, had stated for the record:

> Let us get a false issue off the table: the US does not seek to establish a new international right to abortion, and we do not believe that abortion should be encouraged as a method of family planning (Lederer, 2005).

Later, the combination of President Clinton's support of the ICPD and his support for abortion coverage in the US health care reform so angered the Roman Catholic hierarchy that it sought to discredit the conference by characterizing it as control by the United States. When Vice President Gore attempted to clarify the record, the Vatican attacked the US policy and vice president by name (Gore, 1994). The conference unequivocally endorsed safe motherhood initiatives (after the Holy See was satisfied that they do not include attempts to legalize abortion) and 'expanded condom distribution' to prevent the spread of AIDS and other sexually transmitted diseases (United Nations, 1994).

Some years later, the position of the US Administration in this debate was reconfirmed by US Ambassador to the UN, Ellen Sauerbrey, when she stated at a meeting of the UN Commission on the Status of Women that:

> Non-governmental organizations are attempting to assert that Beijing in some way creates or contributes to the creation of an internationally recognized fundamental right to abortion…… There is no fundamental right to abortion. Yet, it keeps coming up largely driven by NGOs trying to hijack the term and make it into a definition (Singh, 2005).

Fourth World Conference on Women Beijing, 1995

At the World Women's Conference in Beijing in 1995, one of the most spectacular encounters between European and African women took place. It was about the sacrificial role that European feminists ascribed to African colleagues. These were vehemently resisted because they saw the situation of gender as completely misjudged. They pointed out that only the colonial rulers tried to introduce the dominant dualism between the sexes in Europe in the 19th century in African countries. This banished women from reproductive domestic activities in the household and rated their work as inferior to that of the man in professions and politics of the public.

In 1995, reproductive rights once again became the subject of vigorous debates at the UN world conferences, the 1995 Fourth World Conference on Women (FWCW) in Beijing. The Cairo Conference was a notable departure from its two predecessors in a number of ways; for one, it was a large international event, attracting intense media coverage. Secondly, the Cairo Conference involved the participation of many nongovernmental organisations (NGOs), particularly feminist and women groups from various geographic areas.

The Platform for Action, which was adopted by 189 delegations at the Beijing Women's Conference, reaffirmed the Cairo Programme's definition of reproductive health and advanced women's wider interests. Paragraph 96 states:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual

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> respect, consent, and shared responsibility for sexual behaviour and its consequences (Sadik, 1997).

As references to abortion in the review documents needed to be re-negotiated, little time and energy could be devoted to expanding the agenda on abortion in the five-year implementation review of the International Conference on Population and Development and the Beijing Fourth World Conference on Women. Some progress was made at the five-year implementation review of the International Conference on Population and Development, but this process stopped at the Fourth World Conference on Women's review meeting.

The five-year review of the implementation of the Platform of Action of the Fourth World Conference on Women was held in the General Assembly between 5 and 10 June 2000. The Commission on the Status of Women was the preparatory commission for the five-year review process. It aimed to assess achievements made after the World Conference on Women to Review and Appraise the Achievements of the UN Decade of 1985 and the Fourth World Conference on Women. For Kenya, it was bad news:

> …Kenyan women may have little to show for next month when they join other African women in the Ethiopian capital of Addis Ababa in preparation for next year's special Beijing-Plus-Five session in New York… Women are standing where they were in 1995…. The government has not attempted to pass legislation on the Beijing Platform for Action…In Kenya, the process of implementing the resolutions has stagnated, the period between 1995 and 1999 being one in which women participated least in decision-making making, and when poverty increased, women were the first group to be hit (Achieng, 1999).

UN Beijing *Plus Five*, 2000

The Beijing Plus Five was a follow-up of the Beijing Platform's relatively progressive provision on abortion; for instance, governments should 'consider reviewing laws containing punitive measures against women who have undergone illegal abortions'. (Beijing Declaration, 2000). It also contained an evaluative paragraph which provided that '[w]hile some measures have been taken in some countries, the actions contained in [the Beijing] Platform for Action regarding the health impact of unsafe abortion and the need to reduce the recourse to abortion have not been fully implemented'. After midnight on Friday, June 9, exhausted delegates were unable to reach an agreement to adopt the same language agreed to one year prior at the ICPD+5 negotiations; that language provided that governments should 'train and equip health-service providers . . . to ensure that . . . abortion is safe and accessible'. (United Nations, 2000).

Remarkably, during the Beijing +5 negotiations, additional wording echoing the Beijing Platform's language on reviewing laws containing punitive measures was not agreed to due to opposition from a small minority of delegations. The dynamic during that last tense evening of the Beijing+5 negotiations resulted in the Chair of the Preparatory Committee ruling that on the few remaining paragraphs, the action-oriented abortion paragraph among them, contested language would be dropped in favour of verbatim Beijing Platform language. The stalemate that existed at that point effectively meant that only the Beijing Platform language would be adopted without unanimity, a unanimity that was impossible on an issue as controversial as abortion still is (Snyder, 2000).

Nicaragua, supported by the Holy See, introduced an amendment incorporating a 'conscience clause' in the abortion paragraph. It would have permitted physicians to refuse to perform abortions and to deny women information on abortion without requiring such physicians to provide mandatory referrals or to perform abortions in cases where the woman's life is in danger and no other health provider is available. NGOs devoted to women's health and rights mobilized quickly to oppose this amendment, and it was defeated, as it had been at ICPD, Beijing, and ICPD+5. Further, the international consensus has gone as far in its definition of

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reproductive health as including a statement that 'people are able to have a safe and satisfying sex life' (Norr, 1994).

Sexual pleasure for its own sake, however, is not yet on the international agenda. Health, Empowerment, Rights, and Accountability (HERA), one of the international NGOs that lobbied for the sexual rights terminology in Cairo and Beijing, had provided a platform to debate abortion and also agreed on the definition of sexual rights that reached much farther than simply protecting women from harm but towards creating the conditions in which sexuality and sexual experience can be positive and pleasurable. Rather than seeking a commitment to sexual rights solely to avoid discrimination or prevent the spread of HIV/AIDS, HERA argued that sexual rights are valuable in their own right (Garcia-Moreno & Claro, 1994).

In their definition, Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality. This was further interpreted to include having satisfying sex with anyone regardless of sex, and being homosexual in South Africa was in tune with exercising those rights (Christofides et al., 1999). This recognition provided an entry point for promoting actions focusing specifically on the sexual dimension of sexual rights and on building a new culture of sexuality that allows an individual the right of choice, expression, and pleasure (Fanana, 1997). No wonder, in South Africa, there is full legal recognition of gay and lesbian identity. In fact, gay and lesbian groups have mobilized around a human rights discourse. Recently, the economic discrimination faced by gay and lesbian people has been recognized, leading to attempts towards redistribution, for example, to grant same-sex partners the same medical and life insurance benefits as heterosexual married (Klugman, 2000).

Constitutional Changes and Abortion Laws in Kenya, 2010-2019

In 2010, the legal position was changed by the passing of the new Constitution through a referendum, which permitted abortion in certain circumstances. Article 26(4) of the new Constitution reads: 'Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law' (National Council for Law Reporting, 2010).

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 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 Development, 1994). Seen this way, the provision of reproductive healthcare and adequate family planning services, including safe abortion and post-abortion care, form part of the healthcare services to which women are entitled rather than fringe benefits (Guttmacher Institute (2012).

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 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 a need for emergency treatment and (ii) when 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

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allowing the enactment of a law for that purpose. 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 (Ojiambo, 2009).

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's 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. 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 system resources. This is despite the Ministry of Health having developed Standards and Guidelines for Reduction of Morbidity and Mortality from Unsafe Abortion in 2012 (Center for Reproductive Rights, 2010).

In 2011, the Ministry of Health set up a working group to draft guidelines on abortion provision in line with the constitution. The Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion was published in September 2012 and included up-to-date guidance from the 2012 WHO Safe Abortion Guidance. 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 (KHRC, 2010).

As already indicated, in 2010, Kenya also 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' (ACHPR, 2003). This, too, should have opened the door to law reform on these grounds. Indeed, ratification would have led to the country being required to implement this reform. However, Kenya has reservations about Article 14(2C) and does not need to comply with it. It is worth noting, however, that the National Guidelines on Management of Sexual Violence in Kenya do permit abortion in cases of rape or defilement.

Unfortunately, the lack of guidance on how the 2010 change in the Constitution should be implemented meant that both women and healthcare providers remained uncertain of the circumstances in which abortion was legal. At that time, the only guidance available was the government's post-abortion care trainer's manual, which was confusing and contradictory. For example, it stated on the same page: 'The law permits abortion only for the preservation of the woman's life' and 'In Kenya, induced abortion is illegal' (Center for Reproductive Rights, 2010). Hence, one year after the Constitution was amended, the International Planned Parenthood Federation (IPPF) Advocacy and Service (IPAS) Kenya expressed concern that none of the country's health regulatory bodies had reviewed their guidelines on abortion to align them with Article 26(4) of the Constitution (Ngwena, 2013). However, in 2012, there was a revision of codes of ethics and scope of practice for medical doctors, nurses, and clinical officers to allow for certain circumstances for safe abortion (Fjerstad, 2012).

According to data collected for a 2010 report by the Center for Reproductive Rights Kenya (the Center), there were around three court cases every week in which women were charged with having an illegal abortion. This number was believed to be higher for Nairobi (Center for Reproductive Rights, 2010). Further, 10 out of 20 cases examined by their researcher had involved schoolgirls, some of whom were minors. The majority of women arrested for an abortion-related crime were given probation rather than imprisonment. However, those who could not afford to pay bail remained in remand (for an average of one year).

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In 2011, the Ministry of Health set up a working group that included NGOs who supported safe abortion in Kenya 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 (WHO, 2019). They were widely considered to be a forward-looking, comprehensive document. They stated that 'termination of pregnancy is lawful, provided it is performed by a trained and skilled health professional within the confines of the law'.

Abruptly, in December 2013, USAID, which funded much of Kenya's family planning provision, warned that anyone receiving US aid should not attend an upcoming government meeting because the *Standards and Guidelines* were on the agenda. The next day, the Ministry of Health withdrew the *Standards and Guidelines*, arguing that there was a need for wider stakeholder consultation on some of the document's contents. They also halted the safe abortion training programme (Bassett & Naughton, 2015). These actions were a consequence of restrictions imposed under the United States foreign aid policy (the Helms Amendment), which led to all work towards promoting safe abortion in the country by USAID-funded institutions to stop, which is operative to this day. This happened under President Obama, who did nothing about it.

Two months later, in February 2014, the Ministry wrote a letter instructing all healthcare providers to halt safe abortion training and to stop stocking Medabon, the packet of combined medical abortion pills that doctors were giving women in the first trimester. 'Abortion on demand is illegal', the letter said, so 'there is no need of training health workers on safe abortion or importation of drugs for medical abortion'. With such abrupt changes in such a short window of time, it was inevitable that confusion reigned once more among healthcare providers and those seeking an abortion as to what was and was not legally permissible (Kisakye, 2016). There have been reports since 2014 that some police officers and authority figures used the lack of guidance as a means for bribery. Many doctors who are still providing abortions have had to pay bribes to police officers who would otherwise charge them with illegal abortions. However, many providers in Kenya stopped providing abortions altogether, while the number of people who provided clandestine abortions for a fee probably rose (Griffith, 2014).

Given the many repercussions of the withdrawal of the *Standards and Guidelines*, a petition was filed in June 2015 in the Kenyan High Court against the Attorney General, the Ministry of Health, and the Director of Medical Services of Kenya on behalf of the following; the Federation of Women Lawyers (FIDA) Kenya, two community human rights mobilisers, an adolescent rape survivor who suffers from kidney failure and other complications of unsafe abortion, and on behalf of all Kenyan women of reproductive age who were denied access to safe abortions.

The petition calls on the government to restore safe abortion training and reintroduce guidelines clarifying when a legal abortion can be provided. Whereas the petition hearing had been set for 15 December 2016 by a three-judge bench; the case was postponed due to a changing over of judges. A five-judge bench had been arranged to hear this case in May 2017 for directions on how to proceed. This would be a procedural appearance in court, where they would then be given a hearing date. A month later, in July 2015, over 71 organisations in Kenya and Ethiopia sent an open letter to US President Barack Obama, disputing the imposition of the Helms Amendment.

Today, the US Helms Amendment continues to prohibit the use of US foreign assistance for safe abortion, and now in 2017, the Mexico City Policy (commonly known as the Global Gag Rule) has also been re-imposed yet again. On 3 April 2017, the US State Department issued a letter to the US Senate Foreign Relations Committee announcing it would no longer

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und the United Nations Population Fund (UNFPA), which provides maternal and child health services in more than 150 countries worldwide (UNFPA, 2017).

The Civil Society and Implementation of International Strategies in Kenya

Women's movements have been vectors of social and political changes in Kenya, having participated in almost all international conferences and UN meetings. This is so despite being faced with many challenges to gain equality in political, social, and economic aspects of society due to the patriarchal nature of Kenyan society. Equally, some of the most notable women who have contributed immensely to the feminist movement in Kenya and the implementation of international protocols on women include Wangari Maathai, who was an environmental and political activist.

In 1977, Wangari Maathai formed the Green Belt Movement, a non-profit organization that aimed to promote the conservation of the environment and, at the same time, women's rights. She worked to improve women's livelihoods by increasing their access to resources such as clean water and firewood for cooking. The movement also involved women planting trees (National Association of Women's Organizations in Uganda, 2012). Wangari Maathai also spearheaded for right to safe abortion (Mutongi, 2005).

The struggle for affirmative action in Kenya can be traced back to 1996 when the Honorable Charity Ngilu moved a motion in Parliament on the implementation of the Beijing Platform for Action. However, it did not pass. In 1997, Phoebe Asiyo tabled the first affirmative action bill in Parliament, but it collapsed. Despite the fact that the bill was not passed, this created an opportunity for other female members of parliament to push for an increase in the number of women in Parliament. In 2007, the Minister for Justice and Constitutional Affairs, Martha Karua, tabled the Constitutional (Amendment) Bill 2007 on Affirmative Action that aimed at creating 50 automatic seats for women in the 10th Parliament and also created an additional 40 constituencies in Kenya. She defended the creation of 50 special seats as an affirmative action issue, which sought to put women's representation in Parliament at par with their population size.

The struggle for affirmative action finally bore fruit as the Kenya Constitution, which was promulgated in 2010, provides a legal framework for gender equality and women's empowerment. Notably, affirmative action is guaranteed in the Constitution in a couple of provisions, including Article 27 (8), which states that the State shall take legislative and other measures to implement the principle that not more than two-thirds of the members of elective or appointive bodies shall be of the same gender. Article 81 (b) provides that not more than two-thirds of the members of elective public bodies shall be of the same gender.

The Education Center for Women in Democracy (ECWD) conducts capacity building for aspiring women leaders, providing women's human rights education (through training workshops and seminars for community-based human rights educators and policymakers), and engaging in community mobilization. ECWD is also active in women's human rights education, civic education at the community level, community mobilization, training workshops and seminars, development and publications of resource materials, and awareness creation through media and research, and information dissemination on women's human rights issues (Nzomo, 1997).

The Federation of Women Lawyers (FIDA-Kenya) is a non-profit organization committed to creating a society free from all forms of discrimination against women. They have done this through providing legal aid to indigent women, engagement in legal, policy, and legislative reform, treaty monitoring, and research, among other programmatic interventions. FIDA has contributed to advancing women's rights by providing services such as quality legal services to a limited number of women, creating awareness of legal rights, and educating women on self-representation, research, monitoring, and reporting women's rights violations. They also

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lobby and advocate for reforms of laws and policies that discriminate against women. FIDA is also well known for employing women to empower them and involve them in fighting for women's rights in Kenya (Spronk, 2007).

Networks such as The Solidarity for African Women's Rights (SOAWR) Coalition is a regional network comprised of 37 national, regional, and international civil society organizations working to promote and protect women's human rights in Africa. Since its inauguration in 2004, SOAWR's main area of focus has been to compel African states to urgently sign, ratify, domesticate, and implement the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (hereinafter referred to as 'the Protocol'). In addition to campaigns for ratification, the SOAWR Coalition has recently scaled up its focus on the next critical levels of domestication and implementation of the Protocol to translate the ideals enshrined in the Protocol into realities lived and enjoyed by African women. In October 2010, Kenya ratified the protocol (Frederiksen, 2000).

Conclusion

This paper has explored why and how foreign powers and international NGOs have long intervened in Africa and the effects of that intervention on health reforms, especially on the abortion debate. This has been done through such mechanisms as holding regional summits, aid conditionalities, tracking four diplomacies, provision of the free market, austerity policies, and increased foreign military aid. Kenyan women activists, international NGOs based in Nairobi, and political leaders have been at the forefront of domesticating these ideas, but with some level of support from foreign countries. In Africa, Nairobi and Johannesburg have been stellar examples of capitals of change in health reforms and development.

Today, in Kenya, the subject of abortion can be viewed as central to the discourses of politicians, journalists, and academics. Generally, abortion has followed gender issues in moving from the private to the public and political spheres. Historically, the debate has become robust in contemporary Kenya.

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