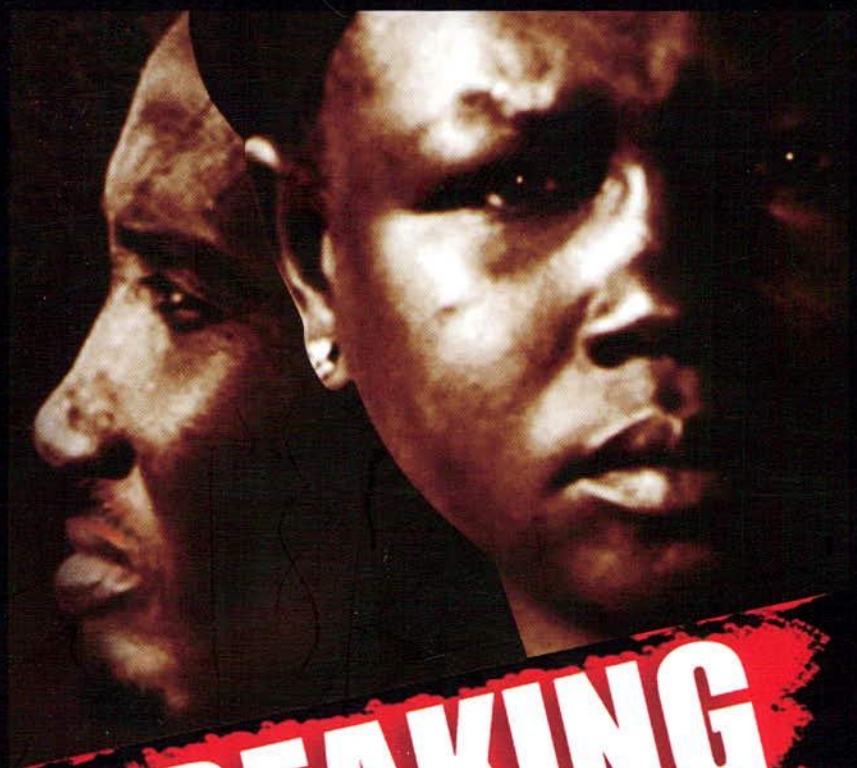
REPORT OF THE ABORTION MOCK TRIBUNAL



BREAKING THE SILENCE

Pamoja Tutetee Haki

KHRC

KENYA HUMAN RIGHTS COMMISSION

RHRA

Reproductive Health and Rights Alliance

REPORT OF THE
ABORTION MOCK TRIBUNAL

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I. ACKNOWLEDGEMENTS

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1. The Organising Committee of the RHRA
2. Hon. Dr. Enock Kibunguchy, former Assistant Minister for Health
3. The Tribunal Moderators
4. The Tribunal Judges:
    - Ms. Betty Murungi, former Executive Director of Urgent Action Fund (UAF) and Vice-Chairperson of the KHRC Board
    - Mr. Steve Ouma, former Deputy Executive Director of Kenya Human Rights Commission (KHRC).
    - Dr. Gachuna, Obstetrician/Gynaecologist, the Kenyatta National Hospital

5. The Health-care providers who testified at the Tribunal:
    - Ms. Monicah Ogutu, a nurse
    - Dr. Otieno Nyunya (Head of Public Health Department, Moi University)
    - Dr. Jean Kagia, gynaecologist with the Protecting Life Movement
    - Ms. Grace Ojiambo, Director of Crisis Pregnancy Ministries
    - Dr. Stephen Ochiel, Chair of the Kenya Medical Association

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II. EXECUTIVE SUMMARY

This is the report of the Abortion Mock Tribunal organized by the Kenya Human Rights Commission (KHRC) in collaboration with the Reproductive Health and Rights Alliance (RHRA). The Abortion Mock Tribunal was held on 26th June 2007 at the Alliance Française Auditorium in Nairobi. The Tribunal was organized with a view to publicize the negative consequences of the criminalization of abortion on the health and well-being of women, and to initiate debate amongst protagonists and antagonists of the legalization of abortion in Kenya. The Mock Tribunal, it is hoped, will break the silence and provide a starting point for the development of a clear and objective policy position on the abortion question.

The Mock Tribunal involved the presentation of pre-recorded testimonies from five Kenyan women who had resorted to unsafe abortions due to a variety of reasons. Thereafter, plenary discussions were held and the judges summarized the key issues emerging from the debate. These issues, which also demonstrate the contours for future debate, are summarized in the following paragraphs.

First, abortion is a reality of life that society must address itself to, therefore, the future lies in holding continuous conversations on the issue until a balance is struck between the two opposing sides. Silence or extremism have no place in these conversations. Furthermore, there are more areas of convergence rather than divergence that should form the stepping-stones towards a mutually agreeable position on the matter. It is a pity that due to the intolerance of some pro-life adherents, the testimony of the women had to be pre-recorded to protect them from reprisals.

Secondly, there are various social and economic considerations that surround abortion cases. The solution does not lie only in legalizing or proscribing abortion, but also in addressing the socio-economic dimensions that influence the phenomenon of unplanned pregnancies and the decisions taken thereupon. For example, it is a fact that more affluent women are able to procure abortions in safe environments – read good hospitals – while poor women have no choice but to employ crude methods or the services of quacks, leading to grave and sometimes fatal consequences. Furthermore, the socio-economic dimension is intricately tied to patriarchy in as far as making decisions on sexual matters is concerned. Majority of women are economically dependent on men, giving men undue advantage over women in sexual matters leaving them to bear the consequences of unwanted pregnancies on their own.

Thirdly, there is a human rights dimension to the abortion debate that needs to be taken into account while seeking the possibilities of a widely acceptable public policy position on the matter. On the one hand, it must be recognized that the woman in an

abortion scenario is inherently vested with rights including those relating to her body, autonomy, reproductive health rights, the right to make choices about her life and the right to participate in public decision-making processes especially over matters that will have a direct impact on her sexuality. On the other hand, there are the competing rights of the unborn child as well as those of the larger society. All these rights are equal and interdependent and must be carefully rationalized.

Fourthly, abortion is most importantly, a public health issue which Government policy must appropriately address itself to. The Government currently ploughs public funds for post abortion care while ignoring the need to invest in the prevention of unsafe abortions. It is time that a cost benefit analysis of this policy position is evaluated in the context of the conventional approaches to addressing public health pandemics. In such an analysis, it must be had in mind that morals belong to individual persons and not governments. In any event, abortion is the result of the breakdown of personal morality. That is, in cases of violation such as rape, the personal morality of the violator. Therefore, it may be a contradiction of terms to invoke personal morality to address abortion cases while in fact the personal morality that is sought to be relied upon is non existent.

Finally, it is true that the accessibility of reproductive health information including increasing accessibility of the choices available to prevent unwanted pregnancies can go a long way in reducing unsafe abortions. It is unfortunate that the fact that majority of the youth neither have the right information relating to their reproductive health nor the accessibility of choices to prevent unwanted pregnancies is in most cases taken for granted. Communication in the family set up, peer education and public education are strategies that should be encouraged to address the menace of unsafe abortions.

III. INTRODUCTION

This is the Report of the Abortion Mock Tribunal held on 26th of June 2007 at the Alliance Française Auditorium in Nairobi. The meeting was attended by civil society representatives, medical practitioners from private and public health institutions and members of the public. The full list of the participants is attached to this Report as **Annex 1.**

The meeting was officially opened by the Hon. Dr. Enoch Kibunguchy, the former Assistant Minister for Health responsible for Public Health. Thereafter, pre-recorded audio tapes containing the testimonies of five women who had undergone unsafe abortions for various reasons were played to the audience at intervals punctuated by skits performed by the Nairobi Peer Educators Group. The audience also had the opportunity to listen to live personal testimonies from individuals who had dealt with abortion related issues. At the end, a panel of Judges summarized the key issues emerging from the debate as elucidated above. The programme of the abortion mock tribunal is attached to this Report as **Annex II**

IV. THE MOCK TRIBUNAL IN CONTEXT

4.1 Selected Statistics on Abortion in Kenya

While Kenya's total fertility rate has declined to 4.7 per cent, and modern contraceptive has risen to 33 per cent among currently married women[1], unplanned and/or unwanted pregnancies are still common. As a result, complications from incomplete abortions are still one of the leading causes of maternal mortality and morbidity.

The 1998 Kenya Demographic and Health Survey (KDHS) reported that almost a quarter of Kenyan women have unmet need for family planning services – 13.4 per cent for spacing and 25.6 per cent for limiting births. Although one third of Kenyan married women are currently using a modern contraceptive method and 7 per cent are using a traditional method of contraception, 48.3 per cent of recent births were still unwanted or mistimed[2].

Kenya's maternal mortality ratio is 590:100,000[3]. Unrecorded deaths in the rural communities make it likely that this is an unreliable and underestimated statistic. One of the major causes of maternal mortality and morbidity in Kenya is unsafe abortion, which contributes to between 30 to 50 per cent of the maternal mortality and morbidity[4].

A recent[5] study in Kenya reveals that 300,000 unsafe abortions are carried out every year of which 2,000 result in death and another 20,000 result in long and short term injuries (pelvic inflammatory disease which include injury to vital organs, infertility and severe haemorrhage). As in many parts of the world where abortion is against the law, those who can afford to pay the price can typically find a medical professional willing to perform a safe, albeit illegal, abortion. But far too often, poor women wishing to end a pregnancy have no choice but to turn to back-alley providers or to self-induced abortion using crude and dangerous methods.

1 Kenya Demographic and Health Survey, 1998
2 Kenya Demographic and Health Survey, 1998
3 UNICEF and WHO, 1996
4 USAID/REDSO ESA, 1997
5 2005 survey carried out by Ministry of Health

4.2 Abortion and the Law in Kenya

The Constitution of Kenya spells out the right to life of all people within its borders. The law therefore permits abortion only for "the preservation of the woman's life" as follows:

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[6]

Relevant sections of the Kenyan Penal Code which bear upon abortion include provisions regarding the *procurement of abortion* (Section 158 of the Penal Code), supplying *implements of abortion* (Section 160 of the Penal Code), and *advertising drugs or appliances related to abortion* (Section 38 of the Pharmacy and Poison Act, Chapter 244), and are described in more detail below.

On procuring an abortion the law states that:

Any person who, with intent to procure miscarriage of a woman, whether she is or not with a child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses force of any kind, or uses any other means whatever, is guilty of felony and is liable to imprisonment for fourteen years.[7]

Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to her self any poison or any noxious things, or uses any force of any kind or uses any other means whatever, or permits any such a thing or means to be administered or used on her is guilty of felony and is liable to imprisonment for seven years[8].

On supplying implement of abortion the Penal Code states:

Any person who unlawfully supplied to, or procures for any person any thing whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or not with a child, is guilty of a felony and is liable to imprisonment for three years[9].

On advertising drugs or appliances for abortion, as stipulated in the Pharmacy and Poisons Act, Cap 244, as revised in 1983 reads:

6 Laws of Kenya, The Penal Code Section 240
7 Laws of Kenya, The Penal Code Section 158
8 Laws of Kenya, The Penal Code Section 159
9 Laws of Kenya, The Penal Code Section 160

Subject to the provision of this Act, no person shall take part in the publication of an advertisement referring to a drug appliance or article of any description in terms which are calculated to lead to the use of drug, appliance or article for procuring the miscarriage of women[10]. *One convicted of conflicting with this section of the law, faces, on the first conviction of a fine of not more than one thousand shillings or not more than three months or both the fine and prison term*[11].

Although the law is fairly explicit and restrictive regarding abortion, there are few examples of enforcement. Studies done in 1980s and 1990s and publicized in the local newspapers estimated that over 250,000 abortions were performed each year and that the majority of these, involved women who were 25 years of age or younger. Other research indicate that 60 per cent of all gynaecological admissions at public hospitals stemmed from induced abortions and that 1,000 to 5,000 Kenyan girls and women died each year from botched abortions.[12] Newspapers frequently carry reports of girls and women dying from complications attributed attempted termination of pregnancies. The methods used by these women have been to either take an overdose of the anti-malarial medication chloroquine or to procure the services of an unskilled practitioner.

While everyone recognizes that illegal abortions are commonplace, prosecutions of both the girls and women who receive them or the providers who perform them are unusual. Newspapers rarely report on such convictions and the qualitative research on abortion in Kenya seldom mentions abortion providers for fear of prosecution as well as a concern informing girls' and women's decisions how and where to procure abortions. Rather, foremost in their deliberations are concerns over the safety and expense of various methods and providers. By maintaining but failing to enforce its prohibition on most abortions, Kenya situates itself as a defender of *sexual morality* and conservative ideals while relegating abortion to an unregulated realm where money largely determines who has access to safe abortions and who does not. [13]

4.3 Abortion and Human Rights

No country has approached abortion law reform as a basic human rights issue for women. Do governments around the world offer more than a token commitment to women's equality as a basic human right? Abortion is first and foremost a human rights and social justice issue. Social justice is not what is administered when all else fails, it is about full citizenship. It is a state of being. Rights are only rights when they can be exercised in an unfettered way.

10 Laws of Kenya, Pharmacy and Poisons Act revised 1983, Section 38
11 Laws of Kenya, Pharmacy and Poisons Act revised 1983, Section 40
12 Lema and Kabeberi-Macharia, Ch-3: Women Who Seek Abortion" in *Review of Abortion in Kenya, 19-27.*
13 Lema and Njau "Abortion in Kenya,"

It is therefore dictatorial, degrading and an insult to the intelligence of a woman to have the decision on whether she will be a mother, imposed on her by law or by a panel, or a doctor, or a priest, then leave her to carry out the responsibility of that decision.

We have been distracted by the pro-choice/abortion rights argument and have failed to see the real issue which is that women are not trusted. Women are not considered capable of making sound and right decisions. The truth is that women are not accepted as full human beings. It is society's inability to trust women's judgment that causes governments to continue to, and in some cases try to, control women's reproductive behaviour with repressive laws that bear on their sexuality.

It is the way that the issues of abortion are handled that really matters - the fear, desperation and ultimately, the oppression and harm experienced by many women when confronted with an unwanted pregnancy. The lack of safe options can be viewed as a form of slavery and compulsory labour (article 4 of the Universal Declaration of Human Rights) when motherhood is imposed. This form of discrimination is unique to women's lives and health and blatant sexism. Where women's access to safe and legal abortion services is restricted, a number of human rights may be at risk as discussed below.

4.3.1 Right to Life

Restrictive abortion laws have a devastating impact on women's right to life. Evidence suggests not only that restrictive abortion laws drive women to unsafe abortion, but that women die from the consequences of such abortions. Approximately 13 per cent of maternal deaths in Kenya are attributable to unsafe abortion. These deaths are largely preventable.

The United Nations (UN) Human Rights Committee and the Committee on the Elimination of Discrimination against Women have repeatedly expressed concern about the relationship between restrictive abortion laws, clandestine abortions, and threats to women's lives. The Committees have recommended the review or amendment of punitive and restrictive abortion laws.

Opponents of safe and legal abortions sometimes argue that the "right to life" of a foetus should take precedence over a woman's human rights, in particular the rights to non-discrimination and health. Some opponents cite a supposed "foetal right to life" as an argument even against the use of contraceptives that work after fertilization but before implantation of a fertilized ovum (the medically accepted threshold for when pregnancy begins).

Most international human rights instruments are silent concerning the starting point for the right to life. Meanwhile, the negotiating history of many treaties and declarations, international and regional jurisprudence, and most legal analysis suggest that the right to life as spelled out in international human rights instruments is not intended to apply before the birth of a human being.

4.3.2 Rights to Health and Health Care

Where there is a lack of legal and safe abortion services and pervasive barriers to contraceptives and other reproductive health services, there will be unwanted pregnancies and unsafe abortions. Both cause largely preventable physical and mental health problems for women. In addition, clandestine abortion clinics and providers have no incentive to be concerned with women's health and lives when they provide their illegal services.

The main UN expert body that supervises the implementation of the right to health—the UN Committee on Economic, Social, and Cultural Rights—has consistently said that respecting women's right to health requires the decriminalization of abortion, at least in some circumstances.

Restrictive abortion laws affect women's health not only by limiting their access to safe abortion services, but also in other ways. For example, the right to health is violated when women are arbitrarily denied treatment for incomplete abortions or when such treatment is given, but available pain medication is withheld.

4.3.3 Rights to Non-discrimination and Equality

Access to legal and safe abortion services is essential to the protection of women's rights to non-discrimination and equality. Women are in practice more likely than men to experience personal hardship as well as social disadvantage as a result of economic, career, and other life changes when they have children. Where women are compelled to have unwanted pregnancies, such consequences forcibly put women at further disadvantage.

Abortion is a medical procedure that only women need. The UN Committee on the Elimination of Discrimination against Women has implied that the denial of medical procedures that only women need is a form of discrimination. Therefore, restrictive abortion laws may amount in certain cases to discrimination against women in and of themselves.

The Committee has also clarified that states have an obligation not to put barriers in place that prevent women's access to appropriate health care. As

examples of such prohibited barriers, the Committee has explicitly cited laws that criminalize medical procedures only needed by women and that punish women who undergo these procedures.

The UN Human Rights Committee has also repeatedly established a clear link between women's equality and the availability of reproductive health services, including abortion.

4.3.4 Right to Security of Person

The right to security of person, including the right to physical integrity, is central to the issue of abortion and human rights. When a pregnancy is unwanted, a legal requirement to continue the pregnancy may constitute a government intrusion on a women's body in violation of this right.

4.3.5 Right to Liberty

When women are sentenced to prison for having procured an abortion, this constitutes an assault on women's right to liberty, because women essentially are jailed for seeking to fulfil their health needs.

The right to liberty is also threatened when women are deterred from seeking medical care if they fear being reported to police authorities by doctors or other medical professionals who suspect *unlawful* behaviour.

The UN Committee on the Elimination of Discrimination against Women has repeatedly urged governments to review their laws to suspend penalties and imprisonment for those who voluntarily procure or induce abortions.

4.3.6 Right to Privacy

Decisions about parenthood are deeply personal, and are precisely the type that privacy rights should protect. A pregnant woman's right to privacy entitles her to decide whether or not to undergo an abortion. No women should have to make this decision under threat of legal prosecution.

The right to privacy is also threatened when health care providers release confidential patient information about women who seek abortions or post-abortion care.

The UN Committee on the Elimination of Discrimination against Women has clarified that the release of confidential patient information affects women differently than men because it may discourage women from seeking and getting treatment for incomplete abortions. Such treatment is essential, and may in some cases be lifesaving. Likewise, not getting this treatment can be fatal.

4.3.7 Right to Information

Under international human rights law, states have an obligation to provide complete and accurate information that is needed to protect and promote the right to health, including reproductive health. Where abortion is not punishable by law, such complete and accurate information includes information about safe abortion options.

Women are disproportionately affected when information about safe abortion services is withheld or restricted. Therefore, restricting or withholding abortion-related information may in some cases also constitute discrimination.

4.3.8 Freedom from Cruel, Inhuman and Degrading Treatment

The UN Human Rights Committee has indicated that restrictions on access to safe and legal abortion may give rise to situations that constitute cruel, inhuman, or degrading treatment. These situations include forcing a pregnant woman to carry an unwanted or health-threatening pregnancy to term.

Evidence suggests that restrictions on abortion often lead to restrictions on post-abortion care. These restrictions can also be incompatible with the right to be free from cruel, inhuman, or degrading treatment. This could, for example, be the case where post-abortion care is systematically denied, or where available pain medication is withheld. It could also be the case when women only have access to necessary post-abortion care if they testify in criminal proceedings.

4.3.9 Right to Decide the Number and Spacing of Children

The right of women to decide on the number and spacing of their children without discrimination can only be fully implemented where women have the right to make decisions about when or if to carry a pregnancy to term without interference from the state.

For this right to be fulfilled, women must also have access to all safe, effective means of controlling their family size, including abortion as part of a full range of reproductive health care services.

In country-specific concluding comments, the UN Committee on the Elimination of Discrimination against Women has recognized that, in some circumstances, abortion will be the only way for a woman to exercise the right to decide the number and spacing of children. This is particularly the case, if the woman became pregnant through rape or contraceptive failure or if family planning services are unavailable.

4.3.10 Right to Enjoy the Benefits of Scientific Progress

The right to enjoy the benefits of scientific progress applies to reproductive health rights. This right may be threatened where women are denied access to new medical technology and drugs that are effective for safe abortions or humanized post-abortion care.

This right may also be at risk when women are subjected to painful post-abortion care—such as curettage, the scraping of a woman's uterus with a sharp instrument—without the use of available pain-medication.

4.3.11 Right to Freedom of Conscience and Religion

Like abortion itself, religious faith is a highly personal issue. The human right to freedom of thought, conscience and religion cannot be limited under any circumstances, and applies to established and non-established religions, as well as to the right not to have a religion.

Freedom of religion includes freedom from being compelled to comply with laws designed solely or principally to uphold doctrines of religious faith. It includes the freedom to follow one's own conscience regarding doctrines of faiths one does not hold.

With regard to abortion, women cannot be compelled to comply with laws based solely or principally on religious doctrines, which many abortion restrictions are. Likewise, where abortion is legalized, women who do not wish to have an abortion for religious or other reasons should not be forced to have one.

Freedom of religion and conscience is often invoked by health practitioners opposed to abortion, claiming a "conscientious objection" to providing certain services, notably abortions. While the human rights framework allows for conscientious objection in some cases, there are limits. For example, conscience cannot justify the refusal to perform a lifesaving abortion when there is no other suitable alternative treatment for the pregnant woman.

The UN Committee on the Elimination of Discrimination against Women has explicitly stated that women's human rights are infringed where hospitals refuse to provide abortions due to the conscientious objection of doctors. The Committee has also expressed concern about the limited access women have to abortion due to conscientious objections of practitioners. The Committee has expressly, in the context of abortion, recommended that public hospitals provide abortion services.

4.3.12 The Concept and Rationale of an Abortion Mock Tribunal

The Mock Tribunal was modelled on similar tribunals organized by feminist groups and networks, often at international meetings or UN conferences, to document violations and to provide a high-profile venue for women's voices to be heard and women's human rights to become more visible. The best example of this approach to advocacy is the Global Tribunal of Violations of Women's Human Rights held at the 1993 UN World Conference on Human Rights in Vienna, Austria. The Tribunal led to recognition by the international community, that violence against women is a human rights violation. The Tribunal also helped to galvanize political will to ensure that steps such as the appointment of a Special Rapporteur on Violence against Women and the adoption of the UN Declaration on the Elimination of Violence against Women were taken.

The Abortion Mock Tribunal sought to dispel the many myths about illegal abortions, that has pushed the stories and pictures of women hurt and dead from unsafe abortions out of sight, hence out of mind, leaving abortion rights supporters feeling guilty and ashamed for believing that women, not just foetuses, have a right to life and liberty.

The Abortion Mock Tribunal was organized to encourage doctors and midwives who have gone underground and continue to do their best with little formal training in surgical abortion to help desperate and determined women safely terminate their pregnancies. Issues were also raised regarding police raids upon doctors undertaking safe but illegal abortions, the public trials, and the loss of medical confidentiality for women.

The Abortion Mock Tribunal also aimed at informing the public that criminalizing abortion would not stop women from having abortions. Furthermore, since the beginning of time, women have risked their lives to terminate unwanted pregnancies. Women will self-abort; have abortions in secret, without medical care, and in dangerous circumstances. The Mock Tribunal illustrated that women's decisions about abortion are about human rights relating to physical safety, personhood, dignity and privacy and, ultimately, the right to life and survival.

In particular, the Abortion Mock Tribunal hoped to achieve the following objectives:-

(i) Documenting and bringing to the fore the complex and often contradictory official Kenyan position towards abortion as well as, the contradiction between law and practice.

(ii) Presenting testimonies that detail the magnitude of abortion to health officials and expert panellists, and to emphasize the structural deficiencies in health facilities underlying such cases.

(iii) Presenting the larger structural deficiencies related to the health care system in regard to abortion cases.

(iv) Facilitating awareness of women's reproductive rights as human rights among target audiences.

(v) Stirring debate that would lead to the development of a solid policy on abortion, which in turn would inform the larger reproductive rights advocacy.

4.4 The Role Players in the Mock Tribunal

The Abortion Mock Tribunal had a number of role players whose functions are described below.

4.4.1 Organizing Committee

The Organizing Committee was made up of members of RHRA and other organizations. The role of the Advisory Group was primarily to guide the overall planning and organization of the tribunal. The members constituted a diverse range of groups and individuals that brought different skills and perspectives to the organizing process. Key members of the group were tasked with the role of identifying the women who were willing to give their testimonies. In the weeks leading up to the tribunal, these members prepared and recorded the evidence of the testifiers.

4.4.2 The Judges

The Organizing Committee was also responsible for the identification of the Judges for the Tribunal. The judges for the tribunal were the following:-

(vi) Ms. Betty Murungi
(vii) Mr. Steve Ouma
(viii) Dr. Gachuna

Ms. Betty Murungi is renowned lawyer and defender of women rights and is the Executive Director of Urgent Action Fund (UAF).

Mr. Ouma was the Deputy Director of Kenya Human Rights Commission and an outspoken human rights defender of many years experience.

Dr. Gachuna is an Obstetrician/Gynaecologist working at the Kenyatta National Hospital

The Judges were deliberately selected from various backgrounds so that they could bring their experiences to bear on the proceedings of the Tribunal. Their role was to:-

(i) Affirm the rights of the testifiers;
(ii) Highlight the ways in which the events recounted in the testimonies violate international human rights standards;
(iii) Situate the struggle for the human rights of the individual testifier within the global movement for women's human rights and accountability;
(iv) Make recommendations and/or call for action toward eliminating the violations recorded in the testimonies;
(v) Outline steps that the testifiers, support persons and members of the audience can take to end these human rights violations;
(vi) Validate the tribunal process; and
(vii) Provide closure to the tribunal as an event

4.4.3 Testifiers

The testifiers were women drawn from different social, economic and religious contexts. The role of these testifiers was to present their story and particularly the circumstances that led to the unwanted pregnancy, the reasons why they opted for abortion and the consequences of the abortion on their overall well-being.

4.4.3 The Audience

The audience was important because it provided the avenue to direct debate on emerging issues. As the list of participants demonstrates, the audience was made up of people from various backgrounds and convictions.

4.4.4 The Moderators

There were two moderators during the Mock Tribunal hearings. Their role was to run the programme and to particularly manage and guide plenary discussions to conclusion. The moderators provided important background information to the audience as well as prompted discussions by identifying, crystallizing and tying up issues during the debate.

(v) Provide safe abortion services where these are provided for in the law, and advocating for expanding indicators for safe abortion services to include pregnancies arising from rape and incest, foetal abnormality and socio-economic factors; and

(vi) Review the existing archaic abortion law to bring it in line with international and regional human rights standards and to remove provisions regarding abortion from the penal code.

5.2 The Pre-recorded Testimonies

5.2.1 Testimony by Margaret

I am 24-years-old and I live in a six room plot in a Nairobi slum with my 11 cousins and 4 brothers; I am the 1st born and since my parent's death I have been responsible for the family. At the request of my mother, I dropped out of high school in 2000 to care for them. She told me she did not have money for school fees. I was only in Form Two. Now I rely on community work for income - my brothers also subsidize the income by selling wares they collect at a nearby dump site. In 2001, a local church sponsored me for a course at a catering college. On May 18th later that year, I baked a cake for my birthday using the skills I had learnt at college - three days later, my mum passed away. She had an abortion which killed her. I only learnt about the cause of her death in 2003. My grandparents hid it from me for two years. My mother bled to death and was alone when she died. She had tried to terminate a 5 month old pregnancy using knitting needles. She was a single parent and my siblings and I are born of different fathers. Rather than bring us up herself, she gave the responsibility of raising us to our grandparents. I first met my mother in class six. When she died in 2001, we were just starting to get close. Her death left her three year old son – my brother - in my care. He is now ten years old and in boarding school.

In 2002, I fell in love with a man. By the end of the year, I was pregnant with his child. He wanted me to have an abortion claiming he did not want another child but the thought had never crossed my mind. Because my mother died from abortion related complications, for me abortion was not an option. So in 2003, I gave birth to a baby boy. When my son was one year old, I got pregnant with the same man again. When I was three months pregnant I told him about it. Shocked and angry he said he did not want another child and I had to 'do something about it or he would leave me'. I talked to my cousin about the pregnancy and the possibility of procuring an abortion. Instead, she offered

to introduce me to an aunt in Tanzania who is barren. There, she said, I would give birth and then leave the baby with my aunt to raise. I wasn't comfortable with this solution because I couldn't see myself giving up my child for good, after being brought up without a mother, I could not imagine doing the same to my child. I felt that I would rather have an abortion than give away the child. So I lied to my cousin that I would go to Tanzania and pocketed the Kshs. 3000 that she gave me for transport.

With the additional Kshs. 3000 that my boyfriend gave me I now had enough money for the procedure. At this point, I was seven months pregnant. The abortion ended up taking place in the backroom of a chemist. The "doctor" asked me to remove my clothes, lie on a bed and part my legs wide. She inserted a pipe deep into my cervix and left it there. I was told to go home and return when I started leaking water. She told me that I should not worry about the pain but instead continue with my normal chores. By midnight, I was in intense pain and water was pouring out of my vagina. I started to bleed heavily. I thought I was going to die. My boyfriend was unmoved. He said that he did not care if I died because he already had a son by me. His attitude angered me because he was the one who would not use a condom. The next morning I went to the chemist in a lot of pain and bleeding heavily. The "doctor" injected me with a drug (I don't know which one(s)) and the pain increased. I started pushing but the 'baby' was not coming out. She then put her hands inside my vagina, got hold of the pipe and stated to pull. The pipe was around the 'baby's' neck. I felt so much pain I thought I was dying. I prayed hard and promised God that I would never do it again. The 'baby' came out dead with the pipe around its neck. The "doctor" disposed the 'baby' and bought me some porridge. I was given some pills and sent home – by then I had been there the whole day. Before I left, I gave the "doctor" the six thousand shillings.

In 2006, I conceived again but miscarried when the pregnancy was five months. I was at home alone when I began to feel weak, cold and in pain as if I had malaria. I was also spotting blood. At 9:00 pm, the pain in my abdomen became very intense. Feeling like I needed to, I lay in bed and started to push but nothing came out. I pushed and pushed for a long time. After a while, a 'baby' came out. When the father of the child came to see him later that night, he found the 'baby' wrapped in papers on the side, I was then in a lot of pain. I lied to him and told him that the miscarriage was caused by malaria. I feel that my miscarriage may be related to the abortion and that my womb may be too weak to hold a pregnancy.

After the miscarriage, I bled for a while. Since then, I have problems with irregular periods as well as a continuous back ache. I am not on any contraceptive even though I am dating again. I fear contraceptives because I have been told they have side effects. I have however been tested for HIV and I am negative. Despite my fragile reproductive health, I have never been examined by a doctor. While my current boyfriend is an understanding man who has promised to marry me, if I became pregnant again and found myself unable to raise a child, I would consider having another abortion. I am not pro-adoption because I could never give up a child of mine. But I will not go through another unsafe abortion. I am not aware of any law or regulation that governs abortion related issues in Kenya but if a friend asked me for advice on whether they should have one, I would encourage them to go ahead but only if the procedure is done safely.

5.2.2 Testimony by Mary

I am 18-years-old and I live in Nairobi with my family. I am the second of seven children. We live with our father because my parents divorced when I was in class three. I dropped out of school in form three because we could not afford the fees. My father does not have a permanent job but occasionally finds work selling goats. My birth mother is a hawker and occasionally comes to visit us at home. My father has since remarried a girl who is about 20 years old. She is a house wife.

In 2005, I was raped and became pregnant. I was 15 years old and in Form 1. The rape occurred on the way to a funeral service of a friend at about 10 at night. On the way, a man called out my name. I ignored him and continued walking but he followed me without my knowledge. I got to a deserted alley close to my destination and suddenly I was surrounded by four men. I started to scream but one of the men jumped on me and covered my mouth. The four of them held me down and raped me in turns. I never told anyone what happened that day but since then, I have hated men. I was shocked when two months later my monthly periods did not come. A pregnancy test confirmed that I was pregnant. As a Muslim, it is disgraceful for a girl to give birth out of wedlock. Pregnant girls could even face death. So I decided to have an abortion but by the time I made the decision I was two months gone. Feigning a week long seminar away from home, I went to a friend's place and told her the whole story. I told her that I wanted to have an abortion but did not have any money. She advised me to drink strong, black tea or concentrated juice and assured me that either of the two could terminate a pregnancy.

I first tried taking undiluted orange juice concentrate but without success. So I decided to try the tea leaves; I boiled 2 packets of tea leaves with half a cup of water and drunk the strong mixture. After about three minutes, I began to feel razor like pains cutting through my abdomen and then I started bleeding heavily. I bled heavily for 6 hours non-stop. After that, I stayed with my friend for 8 days to avoid going home and facing my parents. When I finally went home I was still feeling ill and my step-mother noticed there was something wrong with me. When she asked me I told her that I was fine. I knew that if my parents ever found out what I had done they would punish me severely. My father would probably have chosen to reveal the abortion to worshippers in the Mosque and that would have brought me much embarrassment in the community.

For a month I was home in pain, dizzy and weak because I was not eating much. My step mother wanted to take me to hospital but I declined. I lied to her that I had already seen a doctor who diagnosed malaria. When the pain became unbearable, I went back to my friend and she took me to hospital in her neighbourhood. She paid Kshs. 2500 to have my stomach cleaned. I was told that after the abortion, some blood remained into my womb. After the clean up they gave me some pills to swallow. I have never reported the rape to the police for fear of stigma and my parent's finding out.

I wouldn't advise anyone to have an abortion because my experience was very unpleasant. If my parents were not strict Muslims, I would not have terminated the pregnancy. I only did it out of fear.

5.2.3 Testimony by Sandra as told by her friend

Sandra was 14-years-old when she died. She had just finished primary school. Months before her death she was impregnated by a classmate but successfully hid the pregnancy from her mother for over six months from June to December 2000. During the December holidays, Sandra fell sick and her mother took her to a local hospital. On examination by the doctors, the mother was informed that her daughter was six months pregnant. Shocked and angry she immediately advised her daughter to terminate the pregnancy. Sandra refused.

Without her knowledge, Sandra's mother asked a traditional midwife to carry out the abortion. She deceived Sandra by telling her that it was customary for a traditional midwife to check if the baby was fine. The midwife inserted the sharp edge of a coat hanger through Sandra's cervix, piercing her uterus. Sandra told her mother that she was in pain but her mother reassured her that the pain was normal. The midwife left and Sandra fell asleep in agony. The

V. THE ABORTION MOCK TRIBUNAL IN PROCESS

5.1 Key Note address by Hon. Dr. Enoch Kibunguchy, Former Assistant Minister for Health

Hon. Kibunguchy began his remarks by pointing out that abortion is a global issue with devastating impact on the well being of women. He noted that Kenya, like other countries in the region, was not exempted from the impact of unsafe abortions. He informed participants that in early May 2004 the Ministry of Health, along with the Kenya Medical Association (KMA) and two non governmental organizations (NGOs) released a study, "National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya." He explained that according to the report, approximately 300,000 spontaneous and induced abortions occur each year, putting the national incidence of abortion per 1,000 women aged 15 to 49 at 44.7 per cent. The same report estimated that 20,000 women are treated in public hospitals annually with abortion-related complications and that 800 unsafe abortions are performed every day with 2,600 women dying from unsafe abortions every year.

He went on to state that about 60 per cent of the beds in the gynaecological ward at Kenyatta National Hospital were occupied by patients suffering from post-abortion complications and that unsafe abortion is the cause of 30 to 40 per cent of maternal deaths in Kenya. Referring to a study conducted at the Kakamega Provincial General Hospital, Hon. Kibunguchy stated that abortion accounts for 43 per cent of all cases admitted with acute gynaecological conditions and that nearly half of the patients reporting to the institution with the life threatening gynaecological emergencies are teenagers of about 17 years. He also went on to refer to the Kenya Demographic Health Survey (KDHS) 2003, which had recorded that only 39 per cent of all women surveyed were using some form of contraceptive while the need for family planning was 24 per cent.

Hon. Kibunguchy also revealed that a great number of abortions were as a result of the widespread cases of rape or forced sexual intercourse contributing to unwanted pregnancies. He referred to the 2003 survey of 1,652 Kenya women between the ages of 17 and 77, in which 52 per cent reported being sexually abused in their lifetime while over 30 per cent of the surveyed women reported an experience of forced sexual intercourse in their lifetime. He noted that despite the high incidence of sexual violence, the law does not explicitly provide for access to abortion in the case of rape and incest. He however pointed out that the Ministry of Health's National Guidelines

on the Medical Management of Rape and Sexual Violence provide that pregnancy termination should be discussed with sexual violence survivors as an option in case conception occurs as a result of rape. He regretted that the widespread occurrence of rape coupled with inconsistent access to emergency contraception and the lack of access to safe abortion creates a situation that doubly victimizes women and seriously imperils their health and lives.

On abortion and the law, Hon. Kibunguchy explained that the law in Kenya restricts abortion, except to save the life of the woman. He pointed further that such services can only legally be offered by a qualified doctor registered by the Medical Practitioners and Dentists Board. In this context, he noted that with a low doctor: population ratio, Kenyan women who may need to have an abortion on the grounds of risk to their health, may be denied this service if they do not have access to a medical doctor. Further, he explained that poorer women are forced to have clandestine abortions, often in unsanitary conditions at the hands of untrained practitioners, greatly increasing the risk of abortion-related complications.

He also highlighted the fact that abortion was a challenge to adolescent girls. This is because they are unlikely to be able to access and afford safe abortion services, and may feel additional pressure to terminate the pregnancy because of the social stigma asssociated with the pregnancy and the impossibility of continuing their education. He gave the example of the case of Peninah, a promising young student who in 2005 tragically bled to death following a botched illegal abortion.

In his conclusion, Hon. Kibuguchy expressed the Kenyan Government's commitment to recognizing unsafe abortion as a major public health problem that needed to be addressed urgently. He stated that to address the challenges of abortion, there was need to:-

(i) Strengthen programs for preventing unwanted pregnancies, including creating awareness on sexuality and sexual reproductive health;

(ii) Address the special needs of the youth for comprehensive sexual and reproductive health information and services;

(iii) Improve information and access to contraceptive services including those available to women who have undergone abortion and addressing complications of unsafe abortions through provision of post abortion care at various levels of the health system;

(iv) Train midlevel health care providers, including nurses, midwives and clinical officers, to offer abortion-related services;

next day, her mother made her strong black tea to drink. She started bleeding heavily. Despite taking pain medication the pain persisted.

That night, a six month old 'baby' came out followed soon after by its mother's uterus. The next morning, when the mother found a foetus, plus the uterus next to her daughter, she ran away. Sandra began to groan loudly and this attracted the attention of neighbours who came to her rescue and rushed her to a nearby hospital. She could barely talk and was bleeding heavily. The coat hanger had damaged her uterus and the concentrated tea had only made the injury worse. The doctor advised Sandra's neighbours to report the matter to the police which they did. The police located Sandra's mother at a relative's home but she denied knowledge of her daughter's illness claiming she hadn't been home for a week. She was taken to hospital to see Sandra who immediately rebuked her for "removing" her child. "I will never forgive you Mum." Those were Sandra's last words before she died. Sandra's mother, on realizing the seriousness of the issue, confessed to the neighbours nearby that she only wanted the best for her daughter and it would have been impossible for her to continue with her education and raise a child. Sandra's mother was arrested and charged with murder, a charge which was later reduced to manslaughter. When she was released on a personal bond, she committed suicide by drinking poison.

5.2.4 Testimony by Helga

I am a 24-year-old mother of three. I live in Nairobi with my last born son; my other children (daughter and son) live upcountry with my mother. My parents separated when I gave birth to my second child. My father was angry with me and my mother for having this child and walked out of the family. I dropped out of school in class eight to raise my first child.

I became sexually active at the age of 14. I did not know anything about contraceptives and as a result by the age of 17, I had given birth to my first child, fathered by a man who disappeared when he found out I was pregnant. I sat for my final primary school exams when I was pregnant because I was able to conceal my pregnancy until I was just about to give birth. I never contemplated abortion because my mother had always told me that abortion is a taboo that will result in a curse. Two years after my daughter was born my mother sponsored me to take a hair dressing course. It was during the course that I met the father of my second child. He was very supportive when I conceived but three months into the pregnancy, he was arrested in Kericho and jailed, and he is still in prison. In 2001, I gave birth to a baby boy. My children and I moved in with my mother and I started doing odd jobs in the

slums. Soon after, I met another man and moved into his house. I conceived again and three months into the pregnancy I found out that he was an armed gangster. He threatened to kill me if I left. Eventually, he was shot and killed during a robbery. I decided not to terminate the pregnancy and gave birth to a baby boy, my last born, in 2004. My elder brother then decided to move my mother and my first two children upcountry. He insisted that the last child was mine to raise alone. While he agreed to educate my daughter, my boys were my responsibility alone. I had no source of income when I met another man who promised to take care of my children and I. But when I became pregnant with his child he abandoned me. I moved in with my sister who gave me a lot of problems because of the responsibility of having to take care of her family as well as mine. She gave up and moved out leaving me with my son to take care of. I could hardly make ends meet and decided to terminate the pregnancy – I made a living out of washing people's clothes. I simply could not have another child.

At two months pregnant, I tried to abort by drinking concentrated fluids but this did not work. So I asked the man who impregnated me to finance a visit to the clinic which he did after a lot of persistence. I had learned of a woman who performed abortions for Kshs. 3000 but this price was too high, I simply could not afford her. Other than the Kshs. 2000 I had received to procure an abortion with, I did not have any other money. I approached a man who terminated pregnancies for just Kshs. 2000. After some bargaining, he agreed to carry out the procedure for fifteen hundred shillings. On February 13th 2007, I went to see the man who inserted a pipe into my cervix causing my water to break. By then, I was seven months pregnant. He told me to go home and wait for the foetus to come out. At home I began to have a terrible headache. The next night, I began to feel a lot of pain in my lower abdomen. My youngest son was asleep in the house and the pain was so intense that I did not know what to do. I felt the urge to push and started pushing at around 4:00 am but nothing was coming out. I had been told that concentrated sugar solution would aid the pushing. So I woke up and mixed a quarter kilogramme of sugar into half a glass of water. This made me feel like vomiting and the gagging reflex made it easier to push. I pushed and pushed, at about 6:00 am the 'baby's' legs came out, I got hold of the legs and pulled it out because I could not push anymore, I was too tired. This however did not help, I drank more of the sugar solution and pulled the legs as I tried to push, all this while, my baby was asleep and there was blood all over the floor where I lay pushing. The 'baby' finally came out at 9:00 am in the morning. I was exhausted, and my son was awake and crying. I had to wake up and prepare something for him to drink to calm him down. I did all this while the body lay on the floor with the

blood all over. I gave him some tea and let him out. I knew I had to continue pushing for the afterbirth had not come out. I continued to push and finally at around 10:30 am the after birth came out. The dead 'baby' and the after birth lay motionless between my legs. I gathered enough strength to wake up, wrap the body in papers and clean up a little. I hid the body under my bed for I could not dispose it during the day. When night fell, I disposed of the 'baby' and the afterbirth in a nearby sewage system.

Throughout my life, I have rarely used contraceptives for they cause me a lot of discomfort. I have tried a number of different kinds but I get headaches, feel dizzy and stomach upsets. Right now I am on Norplant which is causing me to bleed uncontrollably. I am considering having it removed. All the men I have been with refuse to wear condoms.

Since the abortion, I suffer serious back pains that make it impossible to work. I have irregular periods during which I bleed heavily. I am now on a contraceptive regime because I cannot endure another abortion. But if I ever got pregnant again I would abort the baby because I cannot afford to clothe and feed another child. My advice to anyone seeking an abortion would be to make sure it happens in a safe environment.

5.2.5 Testimony by Janet

I am 32-year-old mother of two from Eastern Kenya. Three years ago, my husband and I were separated. I had dropped out of school in Form Two to marry him. At the moment, I live with my sister who supports me because I am unemployed. My daughter is 14 and my son is 11. Both children are deaf, mute, and vision impaired. They live with their father who is now remarried. I am a born again Christian who attends church regularly.

I have always wanted to have four children. In 1998, I became pregnant with what would have been my third child. When I broke the news to my husband he told that he did not want another child and said that in any event the decision to have more children was his. He insisted that I must have an abortion, when I tried to resist, he beat me up. I had no option but to agree to do what he wanted for he was the sole provider in our house. So he took me to a private clinic for an abortion. I was four months pregnant at the time. It was a clean clinic owned by my husband's relative. There I was injected with some medicine and taken to a private room; the doctor then inserted a tube into my cervix and used a metal instrument to scrape my uterus. After the contents of my uterus came out, I was cleaned up and injected with a contraceptive that would last for three months. I was not given an appointment for follow-up.

In 2001, I conceived again. I had deliberately neglected to take the contraceptive pill because I wanted to get pregnant again, I hoped, by then, my husband would warm up to the idea. On learning of my pregnancy, my husband was very angry. He demanded that I have an abortion and when I tried to resist again he beat me up. At this point, I knew that I could not have another child without his support for he hardly gave me support with the other two children. Again, I realized that he had not changed as I had hoped. He took me back to the same clinic. I was four months pregnant. The doctor told me that the procedure would be different this time because the pregnancy was more developed. Because of the possible complications, the doctor admitted me into the ward. I was injected with some medicine at 3:00 pm and left on my own. When the pregnancy began to terminate I was alone and in a lot of pain. I pushed for many hours until finally the contents of my uterus came out at 4:00 am in the morning, I even got to see the dead child; there was no one with me through the night. Later that morning, the doctor came and extracted the placenta, cleaned my uterus, gave me an injection for pain and asked me to leave.

My husband was not concerned about me or my welfare and in 2004 he took me to my parent's home and did not return for me. He has married another woman out of pressure from his family who believe it is my genes that cause us to have 'handicapped' children. His relatives used to tell him that he should try having children with another woman for they could be normal. This angered me a lot because I love my two children deeply.

I now live with my sister while the two children live with their father and step-mother. I am not allowed to see the children however, when they are in school, I see them during visiting days. Neither their father nor step-mother visits them. If I had means to bring up my children, I would take them out of their father's care for I do not think that is the best environment for them.

5.3 Testimonies from Health Providers

5.3.1 The Testimony of a Nurse: Ms Monica Ogutu

Ms. Monica Ogutu testified that she works as a nurse at a public hospital and that she has had to deal with cases of unsafe abortion gone wrong every day. She indicated that even health workers who seek to save the lives of women who have undergone unsafe abortions are stigmatized by colleagues. She also noted that they are also traumatized by the conditions of the women they sometimes have to handle. She observed that unplanned pregnancies occur as a result of failure- sometimes personal failure -or the failure of others. She

noted, for example, that for some women, it is not easy to access contraceptives as well as reproductive health information.

Ms. Ogutu testified that one of the most traumatizing cases she had to deal with was that of a 16 year old girl who had been admitted after suffering septic shock following an unsafe abortion. The girl had been attended by a quack who did not know the difference between the 'rectum and the vagina'. The quack had inserted a sharp object through the uterus perforating the rectum consequently; the uterus had to be removed following a lengthy operation. Due to the perforation of the gut, an operation had to be carried out to divert the gut leaving the girl with a permanent colostomy (this is a surgical procedure that involves creating an artificial anus).

She challenged the audience that it was time for the society in Kenya to take action and save the lives of the voiceless women. She concluded that unsafe abortions were easy to prevent but women had to be given choices.

5.3.2 The Testimony of the Head of the Public Health Department, Moi University: Dr. Otieno Nyunya

Dr. Nyunya begun by pointing out that abortion is a public health issue that all countries in the world have to deal with. He noted that each year, at least 20 million unsafe abortions are carried out through out the world and at least 80,000 women die due to unsafe abortions. He explained that at the Moi University Referral Hospital, they have to deal with numerous cases of complications arising out of unsafe abortions every day. He gave the example of a 20 year old girl who had been raped by four men including a former boyfriend. He explained that when the girl came to hospital, she was treated with anti-retrovirals (ARVs) and given a contraceptive. The boyfriend-turned-rapist bribed one of the investigating police officers with Kshs. 5,000 to have the charges dropped. Unfortunately, after three months, the girl came to the hospital where it was discovered that she was pregnant and was seeking abortion services. Having been turned away at the Hospital, the girl had to later be brought back for post abortion care following an unsafe abortion.

Dr. Nyunya explained that if society denies a woman her right to terminate pregnancy in the formal health institutions, the same woman will resort to crude means to procure the abortion. He underscored that the lives of such women could be saved by reviewing the laws and policies surrounding abortion and by providing support to these women. In this regard, he explained that the Kenya Medical Association (KMA) believes that although as a general principle abortion should be proscribed, the final decision of whether or not to carry pregnancy to term following a rape incidence should be left to the woman.

5.3.3 The Testimony of a leading Gynaecologist: Dr. Jean Kagia

Dr. Kagia begun by highlighting the fact that unplanned pregnancies were a social problem that should be dealt with as such. She noted that poverty and particularly the lack of social support systems was a major cause of unsafe pregnancies. She pointed out that legalizing abortion does not remove the social factors that lead women to procure abortion. She emphasized that in such cases the pregnancy is not usually about the woman alone but also about the child and therefore considerations should be made of the child when a decision has to be made on whether to terminate the pregnancy or not. She went further to state that there was no such thing as a safe abortion because in majority of cases, complications arise and therefore the best option would be to encourage women to carry their pregnancies to term. She also informed participants that the health system would not be able to address the influx of patients seeking abortion services if abortion were to be legalized.

Dr. Kagia gave the example of a 21 year old girl she had to deal with. The girl had sought the services of a qualified doctor to procure an abortion but due to mismanagement, the girl's intestines were perforated and she was worried as to whether she could be able to conceive again.

5.3.4 The Testimony of a social worker: Ms. Grace Ojiambo

Ms. Ojiambo begun her testimony by explaining that abortions are carried out because the women involved do not have the resources to provide for the new baby or have no other alternative of dealing with the stigma of early/ unplanned pregnancies. She explained that at the Crisis Pregnancy Ministries where they provide social support to women with unplanned pregnancies, 90 to 95 per cent of women carry their pregnancies to term and parent their child or offer them for adoption. She underscored the fact that abortions, whether carried out by a medical doctor or a quack, destroy the women involved both physiologically and psychologically and as such abortion should not be provided as an option.

She gave the example of a girl who had gone to a good hospital to procure an abortion but after three months the girl was taken in at the Crisis Pregnancy Ministries with hysteria because she could not be able to live with herself after the abortion.

Ms Ojiambo explained that at Crisis Pregnancy Ministries, they had opted to address the problem of unplanned pregnancies by educating school going girls on their reproductive health rights and the choices available to prevent

pregnancy. She explained that they had been undertaking this peer education for a year in more than 90 schools across the country.

In conclusion, Ms Ojiambo cautioned that legalizing abortion would not address the problem of unplanned/ unwanted pregnancies. She also pointed out that society had to be sensitive about the unborn child who, unlike the women, could not be able to present their case before the audience. She noted that by legalizing abortion, the society would encourage the culture of death and increase the number of people who have to make the decision of whether one lives or dies.

5.3.5 The Testimony of a leading Gynaecologist and Chairman of the Kenya Medical Association: Dr Stephen Ochiel

Dr. Ochiel begun by stating that his initial position on abortion at the beginning of his career was that abortion was evil and should be proscribed except in the cases provided for in the Penal Code (to save the life of the mother). He went on to explain that following many years of experience, his position on the matter changed due to the nature and number of cases he had to deal with arising out of unsafe abortion. He gave the example of a 19 year old girl who he dealt with in 1982. He explained that he declined to procure an abortion for the girl on two occasions only for the girl to be found dead two weeks later as she was trying to procure an abortion. He explained that to this day, he has never been able to overcome the feeling of guilt that he might have contributed to the death of the girl. He also gave the example of a 23 year old girl who, because of complications arising out of unsafe abortion, was not able to talk for 3 months. He explained that the girl had sought the services of a quack to terminate pregnancy but the quack had inserted a sharp object into the uterus but unfortunately lacerated the intestines.

In conclusion, Dr Ochiel emphasized that abortion was a public health issue that needed to be addressed as such and detached from individual morals.

VI. PLENARY DISCUSSIONS

During plenary discussions, several issues were raised as summarized below.

1. That, poor women are not able to afford the safe abortions carried out in private hospitals and as such they are the ones who resort to unsafe abortion. In this regard, criminalizing abortion is discriminative.
2. That, whereas it is true that complications do arise during abortions even in good hospitals, there is sufficient technology to ensure that the procedure is relatively safe.
3. That, the Abortion Mock Tribunal was a good idea but all shades of opinions should be included in it. For example, it would have been a good idea to hear the views of the men who in one way or another are associated with the women seeking abortions.
4. Abortion is murder from a Christian perspective and should be proscribed.
5. That, in the debate about abortion, the right of the unborn child should be considered as well. In this regard, the unborn child should not be 'convicted to death' unless they are heard.
6. There is need for sincerity in the abortion debate. It is a fact that many of the people speaking against abortion have had to deal with abortion in one way or the other including procuring or assisting in the procuring of abortion.
7. That, the abortion debate raises the question of when life begins and depending on ones convictions, one can justify or proscribe abortion.
8. That, unsafe abortion must be addressed because they cause 30 to 40 per cent of all maternal deaths and therefore, from a public health perspective, unsafe abortions must be addressed in order to deal with the menace of high maternal deaths.
9. That legalizing abortion is like addressing the symptoms rather than the cause of problem. Abortion does not address the social factors that lead to unwanted or unplanned pregnancies.

10. That, legalizing abortion creates the picture that it is the only option in cases of unwanted or unplanned pregnancies. The reality of the matter is that adoption and the provision of other social support infrastructure such as rescue centre for young poor girls are some of the other options.

11. That, abortion has a human rights perspective to it in which there are competing considerations of the right of the woman and that of the child and a delicate balance must be found.

12. That, legalizing abortion will open the path to safe abortions. This will itself be in fulfilment of the right to health and reproductive health rights of the women involved.

13. That, if abortion is to remain proscribed, the state should provide the women with social support mechanisms to support their unwanted pregnancy/children.

14. That, the discussion on abortion should embrace the big picture: that is, have due regard to the moral, spiritual, emotional and the psychological dimensions of legalizing or proscribing abortion.

15. That, Government policy to provide financial support to post abortion care while at the same time criminalizing abortion is tantamount to legalizing back street abortions.

16. That, instead of spending money on post abortion care programmes, the Government should prioritize preventive services including the provision of information to the youth regarding their reproductive health rights as well as readily available choices as well as the provision of contraceptives in a manner that ensures accessibility of the services to all.

17. That, in the abortion debate, the women's perspective should be given due consideration, as it is the women who get pregnant and have to live with the consequences of keeping or aborting the child.

18. That, the disruptions characterizing the Abortion Mock Tribunal are evidence of the fact that the Kenyan society is intolerant to women interests.

19. That, abortion was evidence of the breakdown of family values. There is therefore need to strengthen family values to curb the high incidences of abortion.

20. That, society should leave it to the women to decide whether to keep or terminate the pregnancy in cases of unplanned or unwanted pregnancies. This is the case because eventually if a woman decides to terminate the pregnancy, she will resort to all means including unsafe abortions.

21. That, giving women choice to determine whether to keep or terminate pregnancies implies that all the range of choices should be available to them and that they should be capable of exercising those choices. One way of resolving the apparent conflict would be to provide the choices but to set standards and regulations regarding how the choices are to be exercised.

22. That, whereas it is true that women enjoy a whole range of reproductive rights including a right to bodily autonomy, it is important to realize that rights are not absolute. However, in cases where a woman has been raped leading to unwanted pregnancy, it would only be fair to allow the woman to decide whether to keep or terminate the pregnancy.

VII. THE JUDGES' RULING/ EMERGING ISSUES

Following the plenary discussions, the judges after due consideration summed up the issues emerging from the proceedings in the Tribunal and the plenary as summarized below. In principle, the summary represents the key issues conceptual and practical issues that surround abortion cases and which need to be taken forward in the abortion debate.

1. That, the Abortion Mock Tribunal is an excellent idea for breaking the silence on abortion in Kenya. This is an important step towards addressing unsafe abortions. Furthermore, it has been proved that talking about abortion helps in reducing the stigma of unplanned pregnancies and in opening dialogue that may lead to solutions that reduce the possibility of unsafe abortions.

2. That, not all the voices had been heard in the Tribunal. For example, there was no testimony from women who had gone to first class hospitals to procure abortion yet it is common knowledge that abortions are also carried out in such hospitals.

3. That, the poor and the vulnerable women are at a greater risk of carrying out unsafe abortions. There is therefore need to address the real needs or factors that drive women to undergo unsafe abortions

4. That, there is need to foster moral uprightness in society in order to address the challenge of unwanted pregnancies

5. That, the abortion controversy is a legal and political power struggle that focuses on the differences between the Pro-choice and the Pro-Life rather than on the common ground between these two positions: that is the desire to save lives.

6. That, in order for a solution to be found, the Pro-life and Pro-choice advocates should vacate their extreme positions and foster dialogue by focusing on the common ground issues.

7. That, given the huge statistics of maternal deaths attributable to unsafe abortions, there is clearly a need to urgently address the problem.

8. That, the high rates of abortion by Kenyan women demonstrate that they have little or no say in negotiating for safe sex.

9. That, the plenary discussions had exhibited a struggle between the young and old and the ability of the patriarchal system to sustain itself.

10. That, there are at least two human rights dimensions to abortion, one is about the violation of the dignity of the women concerned and the other is about the freedom from fear and want. In respect to the latter, it is a fact that fear and poverty that drive women to procure unsafe abortion.

11. That, rape is torture and is a serious human rights issue.

12. That, there is need to address the power/ interest issues in the abortion debate.

13. That, the illegality of abortion, the fear of reprisal or stigmatization or isolation, and poverty related conditions, are some of the factors that push women to procure unsafe abortions. In order to address unsafe abortions, there is need to address all these factors particularly poverty and inequality. To address the latter, there is need therefore to review the laws, policies and regional and global forces that construct poverty. In this regard, it must be put in mind that women are the most affected by poverty and therefore addressing poverty is likely to have a direct impact on the rates of unsafe abortions.

14. That, because Kenya's has ratified various human rights conventions addressing human rights issues related to women, the government is under obligation to address the issues related to the reproductive rights of women.

15. That, abortion is a result of either unplanned or unwanted pregnancy. Therefore, addressing issues related information on and accessibility to contraceptives would go a long way in addressing the problem of unsafe abortions.

16. That, unsafe abortion has been the greatest cause of maternal deaths since the 1950s. In many of our public hospitals, majority of the beds in acute gynaecological wards are occupied by women who have developed complications following unsafe abortions. Time has come for Kenya to address this problem comprehensively. In this regard, there may be need to undertake a systematic and quantitative data collection and analysis to influence action. Kenya should also learn from experiences of other countries.

17. That, the role of health professionals, particularly nurses and doctors, is to save lives. Therefore society should not be judgmental of the nurses and professionals in public hospitals who have to address cases of botched up abortions.

18. That, abortion is a complex social problem that should be addressed without emotion and notwithstanding one's personal convictions.

19. That, unsafe abortion is a burden to health systems of developing countries such as Kenya. Indeed, a study by the World Health Organization has established that the cost of post abortion care is 10 times more than the cost of legal abortions.

20. That, in terms of comparative experience, Kenya can learn from a number of countries such as Zimbabwe where provision of counselling services and contraceptives reduced abortions by 50 per cent. Countries that have legalized abortion include South Africa, Ethiopia and Mozambique. It is interesting to note that in Mozambique, 95 per cent of the population is Catholic.

VIII. THE WAY FORWARD

In terms of the way forward, the participants agreed as follows:-

(i) That once the judges put their verdict together, the same should be circulated to participants.

(ii) That a session should be organized to provide participants with an opportunity to critique the judgment.

(iii) That the judgment should be widely disseminated in order to elicit debate on the national platform.

IX. CLOSING REMARKS

The Abortion Mock Tribunal ended with the delivery of a vote of thanks to all the participants and organizers for a successful event. There was also the expression of hope that the hearings would form the beginning of dialogue that would lead to the development of an acceptable position on abortion in Kenya as well as the institution of programs to address the phenomenon of unsafe abortions for the benefit of all women.

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