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Assessment Piece

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"Just use Coca-Cola": How Kenya's pro-life stance is fuelling an infanticide and backstreet abortion crisis.

It is common knowledge on the streets of urban Nairobi that there are many ways of getting rid of unwanted babies. Approximately 60% of people in Kenya's capital are slum dwellers, many living in Kibera, the biggest slum in Africa, which houses 250,000 of the 2.5 million people in poverty. Here, information travels fast.

Many mothers feed their new-borns Coca-Cola instead of breast milk, knowing it will collapse their organs in a matter of days. Others use ginger-beer, having heard through the grapevine that it works just as well. On the backstreets of slums reside a number of unqualified medics who, for a fee, will induce the infant and kill it with a blow to the head. Hundreds of others are simply abandoned and left to die; tossed into ravines and landfill sites. Discoveries in recent months highlight the grim reality of this crisis, with eight infant corpses having been removed from the Nairobi river during a single week in May 2019. What's more, new government reports claim that on average 15 babies a year are found dead in any one single rubbish dump.

These tales illuminate the plight of women who cannot afford or do not want to raise a family and are failed by the lack of facilities offering abortion services. Whilst there is never an excuse for committing murder, the broader context driving mothers to infanticide must be understood in order to properly tackle the crisis.

Trump's imposing of a "global gag rule" in 2017 saw any organisation offering so much as advice on abortion severed from American fiscal aid. This catastrophic drop in funding towards maternal health centres forced 'Family Health Options Kenya' to shut two clinics and eliminate free outreach care. Being one of only a few non-profit abortion centres in the country, such a decrease in overseas funding remains to this day detrimental to the thousands of women no longer encompassed by their services.

The blame for decreasing accessibility to abortion does not rest on the shoulders of the US alone, however, with an opposition to the pro-choice cause being perpetuated by the Kenyan government themselves. The administrator in charge of approving adverts, Ezekiel Mutua, in fact encouraged Trump's ban and condemned previous American leaders for spurring moral decay in the country by promoting termination services. As he stated during an interview, "Democrats pushed the pro-abortion stance on us - an agenda that is alien to our own culture." One chief medical practitioner deemed America's monetary aid part of a "culture war being fought over the [free-will] of black people"; an attempt to control what Kenyan women do with their own bodies. Ironically, the government choose to take that role upon themselves.

Only in 2010 was abortion legalised for a mother who's health is in danger. What's more, it was still prohibited for victims of rape up until June 2019. Where termination facilities are concerned, only in 2018 did the government lift a ban preventing charity Marie Stopes from providing free maternal healthcare, including advice and support. It's undeniable that such restrictive laws do not deter women from abortion but rather push them towards unsafe methods - procedures so fraught with risk that it is seen as easier to kill the baby at birth.

The lack of societal discourse surrounding termination results in no platform being given to those fighting for self-determination. Subsequently, any possibility of social progress is stunted. So what can be done to aptly tackle this crisis?

Fundamentally, social re-education is needed to reduce stigma and ensure that safe abortion services are not compromised by negative provider beliefs. Both women seeking termination and the clinics offering such services are often libelled or thought of as “baby killers”, and in many shocking cases the practitioners themselves perpetuate this damaging view. In a study carried out by ‘The Population Council’ in Kenya, 100 private pharmacies legally administering abortion drugs were selected and interviewed at random. 27% of pharmacy workers reported having previously denied clients the medicine - 57% of those workers stating it was due to their personal religious or moral beliefs. With the majority of pharmacies in Kenya being privately owned, the presence of corrupt medical practitioners poses a great threat to the already poor accessibility of safe abortion services.

The question immediately follows of why such people are in countenance with legal administration of these drugs. It is imperative to address the social systemic failure clearly prevalent here, where doctors act upon their own beliefs and deny women procedures they are entitled to under law. This unacceptable level of counselling illuminates the necessity for social re-education, in order to diminish damaging perceptions of abortion as much as possible, and subsequently decrease subversion of legal guidelines by individuals.

Additional shortfalls are uncovered when considering how the inadequate supply of abortion drugs Misoprostol and Mifepristone push desperate women to unsafe termination methods. Whilst the medicines are more accessible to those with a steady income in major urban areas, the distribution network fails to ensure that small rural towns and slums are well equipped to meet the level of demand. What’s more, this insufficient supply results in enormous price surges, placing the drugs further out of reach for poor women and the youth who are often unemployed and vulnerable. The Population Council’s study of in-charges at 100 different facilities found the cost of Misoprostol ranging from 360 Kenyan shillings (£2.77), to 5000 (£38.42). For someone living in Kibera this is simply unaffordable, with most residents surviving off 1 shilling a day on average, equal to 0.0077 pence. With the cost of contraceptives spanning anywhere from 50 shillings (£0.39) to 3,500 (£27.29), the issue is further perpetuated, and with cases of assault and rape remaining at an all-time high it becomes even more problematic that safe abortion is too frequently inaccessible.

Making progress towards tackling such a crisis arguably necessitates increased distribution of medicines, as well as governmental interjection to establish more charity centres in rural areas. By increasing the accessibility of free abortion and contraceptive services, the number of women turning to unsafe termination and infanticide would drastically decrease. The question remains however of whether such an argument is merely imposing Western ideology on a country whose ‘anti’ stance on abortion is rooted in notions of culture and tradition. Whilst there remains a need to be respectful, in a country where backstreet terminations kill 7 women a day and hospitalise 320, the scale of this crisis argues that the time for equivocation is over. It is clear that the governmental pro-life mission is not succeeding in eradicating abortion altogether, and to confront the issue there must arise widespread acknowledgement that it shall occur regardless. Instead of attempting to quell the voices calling for action, it is time for the government to fulfil their duty of care. Steps are being taken towards social change, and the 2018 overturning of the ban on Marie Stopes services shows that those in authority are finally listening. Hopefully, this small victory marks the start of many others.