

THE LEGAL CHALLENGES OF NEW REPRODUCTIVE  
TECHNOLOGIES IN KENYA

BY

EVELYNE OPONDO  
REGISTRATION NO. N69/70286/2007


A RESEARCH PROJECT SUBMITTED TO THE INSTITUTE OF  
ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN  
PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE  
DEGREE OF MASTER OF ARTS IN GENDER AND  
DEVELOPMENT OF THE UNIVERSITY OF NAIROBI

2010

*Aj/jc or f*

## DECLARATION

This project is my original work and has not been submitted for a degree to any other university

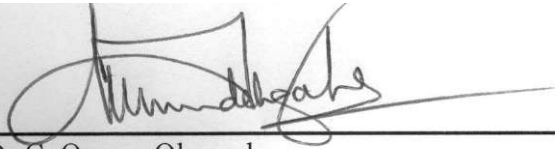


---

Opondo Evelyne

12/07/2010  
Date

This project has been submitted for examination with my approval as the University Supervisor



---

Dr.C. Owuor Olungah

12/07/2010  
Date

## **DEDICATION**

To my mother who is my rock and foundation.

## ACKNOWLEDGEMENTS

I would like to acknowledge the valuable support of my supervisor Dr. Owuor Olungah who went beyond the call of duty to assist in producing this work. His incisive comments made the topic an interesting one to study.

My deep and sincere gratitude goes to my husband Fred for all the encouragement, legal thoughts and the general support. To my father goes my deep felt thanks and respect for his guidance throughout my education. My love goes to my little angel Brayden who arrived in the middle of the research and whose care subtracted a little impetus and reduced the speed of completion. He has however, turned out to be, the biggest inspiration in my life.

I reserve special regards to my informants who believed and trusted in me by sharing their private affairs in a manner that defied the cultural code of secrecy known in our backyard. Without them, there would be no project to write about. I hope that the work will assist in legalizing your plight and according you justice in the long run.

## TABLE OF CONTENTS

DECLARATION	I
DEDICATION	II
ACKNOWLEDGEMENTS	III
TABLE OF CONTENTS	IV
ACRONYMS	VI
ABSTRACT	VII

### CHAPTER 1: BACKGROUND TO THE STUDY

1.1	INTRODUCTION	1
1.2	PROBLEM STATEMENT	4
1.3	RESEARCH OBJECTIVES	5
1.4	JUSTIFICATION OF THE STUDY	5
1.5	SCOPE AND LIMITATIONS OF THE STUDY	6
1.6	DEFINITION OF KEY TERMS	6

### CHAPTER 2: LITERATURE REVIEW

2.1	IN VITRO FERTILISATION PRACTICE AROUND THE WORLD	8
2.2	ETHICAL ASPECTS OF IN VITRO FERTILISATION	10
2.3	LEGAL ASPECTS OF IN VITRO FERTILISATION	11
2.4	HUMAN RIGHTS ASPECTS OF IN VITRO FERTILISATION	17
2.5	THEORETICAL FRAMEWORK	18
2.6	HYPOTHESES	20

### CHAPTER 3: METHODOLOGY

3.1	INTRODUCTION	21
3.2	RESEARCH SITE	21
3.3	RESEARCH DESIGN	22
3.4	SAMPLE AND SAMPLING PROCEDURES	23

3.5	DATA COLLECTION METHODS	24
3.6	METHODS OF DATA ANALYSIS	26
3.7	ETHICAL CONSIDERATIONS	26
<b>CHAPTER 4: DATA PRESENTATION AND DISCUSSIONS</b>		<b>27</b>
4.1	INTRODUCTION	27
4.2	DEMOGRAPHIC CHARACTERISTICS OF INFORMANTS	27
4.3	PERCEPTIONS AND KNOWLEDGE OF IVF	28
4.4	POLICIES, LAWS AND REGULATORY FRAMEWORKS	31
4.5	PSYCHO-SOCIAL SUPPORT	45
<b>CHAPTER 5: CONCLUSION AND RECCOMENDATIONS</b>		<b>48</b>
<b>BIBLIOGRAPHY</b>		<b>50</b>
<b>ANNEXTURES</b>		
	Annex 1: KEY INFORMANT INTERVIEW GUIDE	58
	Annex 2: NARRATIVE GUIDE	61

## **ACRONYMS**

**AIDS**      Acquired Immunodeficiency Syndrome

**ART**      Assisted Reproductive Technology

**DNA**      Deoxyribonucleic acid

**GOK**      Government of Kenya

**HIV**      Human Immunodeficiency Virus

**IVF**      *In vitro* fertilization

**MAR**      Medically Assisted Reproduction

**MOH**      Ministry of Health

**PGD**      Pre-implantation Genetic Diagnosis

## **ABSTRACT**

This study investigated the legal challenges of the new reproductive technologies (NRTs) in Kenya. In this research, new reproductive technology was used to refer to *in vitro* fertilization (IVF). The research intended to contribute to the body of knowledge on IVF and to inform legislative developments in Kenya. At policy level, the research aimed at prompting a more thoughtful regulation of IVF. In particular, this research sought to investigate the extent to which there are laws affecting *in vitro* fertilization and their legal impact; and also to examine the level of knowledge of these laws among men and women in Nairobi.

This study used post modern feminist theory which suggests that various women have different reactions to technologies depending upon their own class, race, sexuality, country, and other factors. The data collection methods used in this study were secondary sources, key informant interviews and narratives. A sample of twenty informants who had knowledge or experience in NRTs were interviewed.

The findings of the research indicate that, whereas, perceptions and knowledge is important in determining the ease of access to IVF, there is a general lack of knowledge and information on it, its availability and the legal challenges it raises in Kenya. The findings further reveal that the cost of IVF is prohibitive and has served to impede access to this technology. The study also found that women bear the greatest burden as a result of IVF which is largely unacknowledged by their families.

The study recommends that the government comes up with policy and legislation on NRTs. Further, that there is need for a general awareness of the public on IVF, its availability, implications, cost and possible effects and lastly, that the government should subsidize the cost of accessing NRTs so as to make it affordable to the majority of Kenyans.



## CHAPTER 1: BACKGROUND TO THE STUDY

### 1.1 INTRODUCTION

"Reproduction" in anthropology refers to the processes by which new social members are produced—specifically, the physiological process of conception, pregnancy, birth and child-raising. In its wider sense, "reproduction" is used to encompass the processes by which societies are reproduced for the future (Floyd and Franklin, 2005/

The new reproductive technologies constitute a broad constellation of technologies aimed at facilitating, preventing, or otherwise intervening in the process of reproduction. These interventions focus predominantly, although not exclusively, on the female body and, with some notable exceptions (for example, a privately arranged and implemented donor insemination), operate within the medical domain (Ritzer, 2006). In this study, however, new reproductive technology was used to refer to *in vitro* fertilization.

*In vitro* fertilization (IVF) is one of the assisted reproduction technology (ART) fronts often used to treat infertility that is caused by damage to or blockage of a woman's fallopian tubes, male infertility, and persistent infertility for which other treatments have not worked (Cook et al., 2003). It refers to removing one or more oocytes from a woman's ovary by laparoscopy and then fertilizing them by exposing them to sperm under laboratory conditions outside the woman's body.

In IVF, oocytes which are obtained surgically from ovarian follicles in super-ovulated cycles and prepared sperm are brought together in a dish in the laboratory. Fertilization takes place outside the body (*in vitro*=in glass). Cleavage stage embryos derived from these fertilized oocytes are then placed in the uterus (Braude and Rowell, 2003/ On 25th July 1978, Louise Joy Brown was born in Great Britain. She was the first successful birth through the use of *in vitro* fertilization (Sgambati, 2007).

In cases where a woman cannot conceive as a result of defective oviducts, an egg can be removed surgically from her ovary and fertilized "in vitro" in a Petri dish under laboratory conditions that are as suitable as the environment inside the oviduct where

fertilization normally takes place. The embryo is then transferred to the woman's uterus to develop normally. A donor ovum rather than the woman's own ovum can also be used for the woman who does not ovulate or who carries a sex linked disease that she does not want to pass on to her children.

Bodily experiences like that of infertility and its treatment are shaped by cultural, political and social environments that influence our definitions of the normal, the painful and the reparable (Carmeli and Dirnfeld, 2008j). It is estimated that 10-25% of adult couples in Africa are sub fertile and of these, female factors account for about 55% of the causes, male factors account for 30-40%, while 5-15% of the causes are unexplained (Giwa-Osagie, 2002).

The most common cause of infertility in Africa is infection of which the two sexually transmitted infections, gonorrhoea and chlamydia are the main culprits in both male and females. Delayed diagnosis of sexually transmitted infections, lack of diagnosis, incomplete therapy, no therapy, or inappropriate therapy compound the problems of sexually transmitted infections in Africa (Giwa-Osagie, 2002).

The problem of infertility is a major one especially in developing countries where its effects extend beyond the loss of human potential and unrealized self and instead poses unique difficulties such as economic hardships, social stigma and blame, social isolation and alienation, guilt, fear, loss of social status, helplessness and, in some cases, violence. At the same time, many families in developing countries depend on children for economic survival (Daar & Merali, 2002).

The Kenya National Reproductive Health Policy (MOH, 2007) underscores infertility as an important public health concern in the country but which has been inadequately addressed at both policy and service level, mainly due to its ranking against other perceived pressing priorities of maternal and child health care. The policy notes that reproductive health providers must endeavour to eliminate factors that impede equitable access to reproductive health services and in particular the reduction of financial, social, political and cultural barriers to those seeking reproductive health information and

services, especially among the vulnerable members of the population such as the infertile couples (MOH, 2007).

Technologies such as *in vitro* fertilization and other assisted reproductive technologies inevitably provide normative challenges as they widen the scope of reproductive options and contest the traditional notions of motherhood, pregnancy and childbirth. Predictably, new technologies and capabilities prompt medical and legal discourses, usually representative of the dominant power groups within society, which may act to either encourage or discourage consequential social adjustment (Paterson, 2004).

The development of law in any society is dictated by the values of the specific historical, social, economic and political demands of the particular society in question. The ruling class or ruling groups which articulate the norms and structures usually define the type of legal development a society undergoes. Law and development, in this context define arenas for political and ideological struggle, since there are always classes and groups fighting to control the direction of change in society (Oki-Ombaka, 1989/

As a political arena, law represents a montage of compromises, defeats, and victories of past struggles. As a battleground, it is perceived as defining the means through which change can be effected or existing arrangements protected by beneficiaries of existing arrangements. Alternatively, it may be seen to legitimize the existing injustices experienced by marginalized individuals and groups in society (Oki-Ombaka, 1989).

This study anticipated that there was need to seek information on the legal implications of access to IVF services for women of reproductive age in Nairobi, Kenya. The study investigated the social foundations of laws and policies affecting IVF as well as the legal challenges thereto. It examined how these laws seek to preserve the status quo of what are perceived as societal values or morals. IVF procedures are relatively new in Kenya, the first Kenyan child conceived through the procedure having been born in 2006. Kenya is still grappling with the new technology and although not having been used by many women in the country, the demand is rising and thus the need to ensure accessibility as well as the protection of the rights of those accessing it. In Kenya, the fact that IVF

services are solely offered by private practitioners in private facilities under no legislative control may mean that the providers of this service may use their own paternalistic forms of discretion in patient selection or de-selection.

The Kenya government policies and efforts have in the past been concentrated at reduction of population without putting any effort in assisting those who are unable to get children to do so through new technologies. This study therefore, investigated the policies of the government with regard to IVF to determine whether they create an enabling environment for those in need of assisted reproduction or not.

## **1.2 PROBLEM STATEMENT**

The legal problems that arise from in vitro fertilization are many and may include disputes such as who has parental responsibility over a child begotten from IVF. The number of persons who might assert parental rights over a child begotten from IVF are now expanded to five, that is; the sperm donor, the egg donor, the surrogate womb mother, and the couple who raises the child.

IVF also raises questions of rights and liabilities as they apply to the foetus, donors, and adoptive parents, as well as the role of physicians and parenthood organizations, researchers, corporations, and government. This study reviewed existing statutes and policies in Kenya that deal with these issues against the understanding that policies influence not only people's conduct but also their subjectivities and beliefs.

This research endeavoured to answer the following questions:

- a) Are there any existing laws or regulatory frameworks in Kenya relating to IVF and if so which ones and how do they affect women?
- b) What are the legal factors around IVF services in Kenya and how do they affect women?

- c) What is the level of knowledge of the laws relating to IVF among lay men and women in Kenya?

### **1.3 RESEARCH OBJECTIVES**

#### **1.3.1 Overall Objective**

The overall objective was to explore the legal issues in Kenya arising prior to accessing IVF services as well as after a successful IVF which may promote or hamper an individual's use of the services.

#### **1.3.2 Specific Objectives**

- a) To investigate the extent to which there are laws affecting *in vitro* fertilization in Kenya.
- b) To investigate the legal impact of *in vitro* fertilization for men and women in Kenya.
- c) To examine the level of knowledge of the laws affecting *in vitro* fertilization among men and women in Nairobi.

### **1.4 JUSTIFICATION OF THE STUDY**

This research aimed at contributing to the body of knowledge on IVF and to inform legislative developments in Kenya. At policy level, the research aimed at prompting a more thoughtful regulation of IVF in Kenya. Perceptions and delineation of the most important issues in this area should serve to stimulate the development of medico-legal guidelines and corrective legislation prior to the occurrence of a genetic tragedy. There was, therefore, need to examine the legal issues around IVF for the population in Kenya including the legal challenges that may occur after a successful IVF. There was also need to examine the social factors that shape different legal responses to technology especially

those that reflect the gender divisions of inequalities. The findings of this study will also serve as a theoretical contribution to the virgin debates surrounding IVF in Kenya.

## **1.5 SCOPE AND LIMITATIONS OF THE STUDY**

The study was limited to legal scholars, reproductive health experts and persons of reproductive age in Nairobi who have undergone IVF or who wish to undergo IVF. Kenya does not have any specific laws on reproductive technologies nor has it had any litigation around reproductive technologies. Therefore, the study looked at the likely interpretation of available laws and largely borrowed from the experiences of other jurisdictions.

Matters of reproductive health are very sensitive in their nature and as such, there were only a limited number of informants willing to be interviewed on the subject matter of study. The study acknowledges that there is lack of adequate information on the new reproductive technologies which may have limited its findings. There was also a challenge in finding the number of experts initially proposed as there were not many people versed in the area of new reproductive technologies and therefore, 20 key informants instead of 25 were ultimately reached.

## **1.6 DEFINITION OF KEY TERMS**

Many of the terms used in this study had varied meanings and by defining them it was hoped that the context in which they were used would be clarified.

**Infertility:** the inability to have a child without assisted reproductive technology.

**New reproductive technology:** referred to *in vitro* fertilisation.

**Assisted reproductive technology:** technology used to treat infertility that is caused by damage to or blockage of a woman's fallopian tubes, male infertility, and persistent infertility for which other treatments have not worked.

**Women:** female adults of **18** years and above who are interested in having children. They form the potential users of the *in vitro* fertilization techniques

**Accessibility of IVF:** the ability to obtain the services when in need without hindrances such as lack of information or exorbitant costs associated with it.

**Legal factors:** referred to the implication of the Kenyan laws on new reproductive technologies and included existing laws relating to assisted reproductive technology and any existing regulatory frameworks in Kenya.

**Lay men and women:** referred to men and women who have no professional training in relation to reproductive health

## CHAPTER 2                    LITERATURE REVIEW

### 2.1    *In vitro* fertilization practices around the world

In Australia and other countries, certain groups of women have traditionally been denied access to assisted reproductive technologies (ARTs). These typically are single heterosexual women, lesbians, poor women, and those whose ability to rear children is questioned, particularly women with certain disabilities or who are older. The arguments used to justify selection of women for ARTs are most often based on issues such as scarcity of resources, and absence of infertility (in lesbians and single women), or on social concerns: that it "goes against nature"; particular women might not make good mothers; unconventional families are not socially acceptable; or that children of older mothers might be orphaned at an early stage (Peterson, 2005).

Peterson (2005) refers to a study by Steinberg (1997) on attitudes held by ART medical staff which found that there was a common belief that, inherent in their medical responsibilities, IVF professionals were obliged to use their "common sense" about facilitation of "appropriate" reproduction and in the judgment of parenting ability. In that study, the vast majority of respondents admitted that they would refuse to treat women who were neither married nor living in a long term heterosexual relationship out of concern for the potential child's need to have an appropriate family unit that included both male and female parents.

Post-menopausal women who wish to benefit from assisted reproductive technologies sometimes suffer discrimination when trying to access these services. These women require donated ova to achieve IVF pregnancies. In the past, excess ova harvested after hormonal stimulation of young women undergoing IVF were donated in significant numbers. Improved techniques, including embryo freezing, have however reduced the number of excess ova available for donation (Peterson, 2005). This coupled with negative attitudes toward the post-menopausal women has significantly reduced their chances to benefit from the new reproductive technologies.



In contrast, however, the world's most intensive consumers of IVF are Israeli women, whose fertility treatment is state-funded. Nearly unlimited treatment is offered to every woman, irrespective of her marital status or sexual orientation, until she has two children with her partner (Carmeli & Dirnfeld, 2008). Israel's reproductive policy is widely known as pronatalist, "Zionistically" associating reproduction with the Israeli-Palestinian conflict by declaring the enlargement of the state's Jewish population an important component of nation building (Carmeli & Dirnfeld, 2008). IVF and all related technologies, most notably intracytoplasmic sperm injection (ICSI), used to overcome male infertility, are offered free of charge to any Israeli woman up to the age of 45. The age limit rises to 51 if using donor eggs. No psychological, educational or financial requirements apply. State funding is limited to two children with the woman's present partner (if she has one), irrespective of the number of her or the partner's children from previous relationships (Carmeli & Dirnfeld, 2008).

In 1983, The State of Victoria in Australia presented a report on *in vitro* fertilization and another Report in 1984 on Disposition of Embryos Produced by *in vitro* Fertilization. Following the recommendations of these reports, the Victorian government enacted the Infertility (Medical Procedures) Act which sets out the provisions to regulate IVF and associated technologies (De Melo-Martin, 1998). In 1992, the British Parliament established the Warnock Committee that produced the Report of the Committee of Inquiry into Human Fertilization and Embryology which later became the Human Fertilization and Embryology Act. There were many areas of commonality between the Australian and British assessments. For married or stable couples, all of the reports concluded that artificial insemination and IVF are legitimate medical responses to infertility but that informed consent is a precondition for treatment. They argue that some forms of embryo research such as cloning, clearly are unacceptable. However, other forms of embryo research are permissible within the first fourteen days of development *in vitro*, provided that ethics committees regulate and approve them. The commissions also agreed that governments should allow the donation of embryos. Similarly, the reports

concluded that governments should regularize the legal status of children conceived through the new reproductive technologies (De Melo-Martin, 1998).

In order to highlight the current status of available literature, the ethical concerns in accessing IVF, the legal issues arising from IVF and the human rights issues arising from IVF have been reviewed.

## **2.2 Ethical aspects of IVF**

Ethical issues raised by Medically Assisted Reproduction (MAR) have been considered so profound that several countries, particularly those where the more advanced reproductive technologies are applied, have created national commissions to address them and propose legal regulatory framework and other responses. The International Federation of Gynecology and Obstetrics (FIGO) Committee for Ethical Aspects of Human Reproduction and Women's health has made statements and recommendations, notably on Ethical Guidelines on the sale of Gametes and Embryos (1996), Donation of Genetic Material for Human reproduction (1994) and Ethical Aspects of Gamete Donation from Known Donors (Direct Donations) (2000) (FIGO, 2006).

National and other public commissions tend in general to address Medically Assisted Reproduction (MAR) at the macro ethical rather than the micro ethical level, considering the impact for instance of gamete and embryo transfer and surrogate motherhood in terms of social policy rather than of overcoming childlessness in particular patients. With regard to children produced by MAR technologies, however, commissions often come to the micro ethical level to consider the experience of children who are genetic offspring of only one, or neither, of their social parents (Cook et al., 2003).

Among the practical concerns raised by IVF which have ethical and legal implications are disposal of surplus embryos created *in vitro* that prove unnecessary or unsuitable for a couple's reproductive requirements, implantation of several embryos that results in high,

multiple pregnancy, and creation of the same result by natural conception following medically induced super ovulation, and the option of so called 'selective reduction' to reduce multiple pregnancy. Multiple pregnancy involves health care of mothers, foetuses *in utero*, and newborn children, possibly born prematurely with low birth weight and risk of associated complications (Cook et al., 2003).

From the above literature, there is clearly a lot for Kenya to consider being that Kenya is yet to come up with clear guidelines on this procedure. This study sought to fill in the gaps in knowledge and investigated the moral issues that may hinder women's access to IVF in Kenya.

### **2.3 Legal Aspects of IVF**

In looking at the legal implications of IVF, the study looked at the effects of the national constitution, national laws and international conventions and how they serve to determine the scope and limits of conscientious objection to delivery of IVF services and the facilitation of conscientious decision making by women on whether to access those services or not. In so doing, the study sought to separate the appearance of equality as manifested in the legal instruments from the actual experience of those on whom the legislation is expected to have an impact.

According to Cook and Ngwena (2006), there are three legal principles that are key to advancing women's reproductive and sexual health. First, law should require that care be evidence-based, reflecting medical and social science rather than religious ideology or morality. Second, legal guidance should be clear and transparent, so that service providers and patients know their responsibilities and entitlements without litigation to resolve uncertainties. Third, law should provide applicable measures to ensure fairness in women's access to services, both general services and those only women require.

Central legal issues in assisted reproduction are the consent of both members of an infertile couple, consent of gamete or embryo donor, and the legal status of a resulting

child. A husband's consent to his wife's insemination by donor is usually required, in order that any legal presumption of his fatherhood be maintained. His objection would render the child not his legal responsibility, and he may disclaim paternity if the wife is serving as a surrogate mother to another man's child. Sperm or ovum donors must consent for lawful donation, but recovery of sperm from unconscious and recently deceased men raises concerns such as how one can prove that his consent was obtained in his unconscious state or before his death (the case of *R. V. Human Fertilization and Embryology Authority, exp. Blood* (1997) 2 All ER 687 (Court of Appeal, England)). Legal questions that are also unresolved in many countries arise when donation of a couple's cryo-preserved embryo is possible, but only one member of the couple consents.

The UK Human Fertilization and Embryology Act 1990 Code of Practice states that licensed centers providing ART services must also take into account the welfare of any child who may be born as a result of the treatment including the need of that child for a father, before providing a woman with such treatment. In Australia, the states adhere to the National Health and Medical Research Council guidelines which guideline for many years referred to the fact that IVF should only be available to people within accepted family relationship but failed to provide a definition for this concept. In 1996, the council revised these guidelines and omitted the words "accepted family relationships" (Peterson, 2005;).

Specific laws may concern such matters as spousal consent, gamete acquisition and donation, and disclosure among themselves of identities of different participants. Medical licensing authorities and professional associations may adopt practices that practitioners are required to observe, such as on age limits beyond which motherhood should not be assisted, and limiting numbers of *in vitro* fertilized embryos that may be placed *in utero* in a single treatment cycle.

Homosexuals also experience difficulties in accessing assisted reproductive technologies as the society has largely failed to view them as acceptable relations. Anderssen (2002, cited in Peterson 2005) observes that it has traditionally been assumed that it is important

for children to have both male and female role models within the primary family unit, for healthy psychosocial development. However, psychological studies of children raised in family units with homosexual parents have found no significant negative impact on cognitive development and function, emotional adjustment, gender identity or behaviour when compared with children of heterosexual couples or single mothers.

Anderssen (2002, cited in Peterson 2005) further notes that with the failure rate of modern marriages approaching 40-50% in many countries which also have the highest number of ART services, a significant number of families have minimal or no contact with a father figure and there are obviously no guarantees that heterosexual couples will remain married or as a couple throughout their offspring's childhood. It would therefore, be an inappropriate discrimination to exclude lesbians, single heterosexual or postmenopausal women from access to ARTs because of concern for the welfare of their potential offspring.

There is a moral dilemma in trying to balance the welfare of the child and the right of the would-be parents to procreate. Every characteristic of those who request medical assistance that does not conform to the "heterosexual married parents with their genetically related children" pattern is assumed to result in negative consequence for the child (Pennings, 1999). Where laws focus on children's welfare and avoidance of the stigma of illegitimacy, strong presumptions are that children born during marriage, or within some generous time after it ends by the husband's death or divorce, such as 300 days, are the husband's legitimate children, unless he actively denies this. The Kenyan Evidence Act (Chapter 80 of the Laws of Kenya) states that the fact that any person was born during the continuance of a valid marriage between his mother and any man, or within two hundred and eighty days after its dissolution, the mother remaining unmarried, shall be conclusive proof of the legitimacy of the child.

Many of the initial objections to IVF technology were based on fears and assumptions that the physical and/or psychological development of children born as a result of these technologies would be impaired by the artificial way in which they had been conceived.

There was perceived anticipation of increase in potential for aberrant parental bonding as well as an expectation of probable social stigmatization of IVF offspring. The vast majority of studies undertaken to investigate these concerns have, however, found very little, if any, significant difference in physical development or psychological wellbeing in IVF children as compared to non-IVF children (Peterson, 2005).

One of the consequences of assisted conception is the issue of parental responsibility of a child begotten of IVF. This is adequately demonstrated in the American case of the Calverts. "Crispina and Mark Calvert were unable to conceive a child due to the fact that Crispina had had hysterectomy. Her ovaries, however, were intact and capable to produce valid ova. Therefore, they drew up a contract with Anna Johnson who agreed to be a surrogate mother and later relinquish the child to the Calverts. Calverts agreed to compensate Johnson \$10,000 in three installments part paid before and part after the birth of the child. After successful *in vitro* fertilization and transfer of the embryo to Johnson's womb, Anna required full payment of the sum threatening that otherwise she would keep the baby. Three successive courts decided in favour of Calverts. The basis of the decision was different in different courts: two courts relied directly on genetic relatedness of the Calverts to the child and invoked the assumptions of other possible ways of determination of parenthood. The third and final court based its decision purely on the concept of 'intent' of the parties, that is, what was the intent of them when they entered the contract"? (Sedlenieks, 1999:5-7).

Sedlenieks further observes that

"...this court case reveals two aspects of the impact of the new reproductive technologies in defining kinship and gender. First, it demonstrates that due to the new reproductive technologies, society is forced to re-evaluate its assumptions about what is the basis of kinship and gender relations. Second, they show that the 'biogenetic' basis, although perceived as the basis, can not be applied in the real situations. The procreative act, marriage, donors of genetic material and the ones that engage in the nurturing of the new creature (embryo and later the child)

can all now be separated. Prior to the new reproductive technologies, they all were supposed to be parts of the same biologically grounded process. Since these roles can be delegated now to different people, one cannot use the biological processes as the determining factor to identify the kin persons. The intention of the court to put more emphasis on the social seems to be logical since it still can identify one person. While the biological facts have become confusing, the social ones remain the same as before."

The law on medical negligence applies to health assessments of women for pregnancy and to the screening of sperm donors regarding their genetic health and freedom from sexually transmitted diseases, including HIV infection. It may also apply where physicians undertake to select donors of specific ethnic or racial origins or body builds such as to match women's husbands. Where advanced techniques of gamete or embryo screening are available, such as pre-implantation genetic diagnosis, practitioners are obliged to discuss them with patients unless these procedures are obviously beyond patient's financial means. Damages awarded on birth of a disabled child may be substantial, but may be more modest when healthy but ethnically or otherwise mismatched children are born (Cook et al., 2003).

In addition to their legal accountability to patients, practitioners are legally accountable to professional licensing bodies and medical associations for incompetent and unethical practices, such as deceptively inseminating patients with their own or otherwise unapproved sperm.

Mistakes identified during IVF procedure in the Netherlands and USA point to the need for more stringent regulation and monitoring. In 1993, a white Dutch couple gave birth to twins-one white and one black. It was found that the pipette used to fertilize the ova had not been properly sterilized and contained sperm from both the woman's husband and another man, who was black (Frith, 2002).

In New York in 1998, a white couple had a black and a white twin. In this case, the white woman received the fertilized egg of a black couple along with her own egg fertilized by her husband. The mistake was discovered when she was four months pregnant. She did not want an abortion and after the children were born, she wanted to keep both. The black couple, who did not succeed with further IVF procedures, launched a custody case for their biological son. The white couple eventually agreed but obtained visiting rights to ensure the twins grow up knowing each other. Both couples sued the hospital concerned (Frith, 2002).

Dickens (2008) observes that Courts have been quite consistent in allowing ex-partners in marriages or similar relationships, usually men, to veto the other partner's reproductive use of jointly-created IVF embryos. This supports the principle of voluntary parenthood. In contrast, child custody disputes following surrogate motherhood may favor the commissioning couple or the surrogate. Decisive are the best interests of the child, which a court may find favorable to the former or the latter, or custody shared between them. Pre-implantation genetic diagnosis (PGD) may be restricted by governmental licensing regulations, and raises concerns about diagnosis showing non-inheritance of a feared disorder, but not other conditions harming a subsequently born child. Some countries explicitly allow nationals to go to other countries for services legally barred in their own whereas, other countries bind their nationals by their prohibitive laws in which case, if they were to receive these services abroad which are lawful where they are delivered, they would still raise concerns of legality for the person in her country of origin.

The issue of multi-foetal pregnancy reduction, and in some countries of disposal of surplus embryos *in vitro* or in cryopreservation, raises questions of how local abortion law is worded and applied. The challenge is to consider multi-foetal pregnancy reduction not as abortion *per se*, which ends pregnancy, but as a means of preserving pregnancy against the danger of spontaneous abortion of all embryos or foetuses *in utero* (Cook et al., 2003). The Penal Code (Chapter 63 of the Laws of Kenya) has no clear position on this and provides that any woman who, being with child, with intent to procure her own



miscarriage, unlawfully uses any means or permits such use to procure her miscarriage is guilty of a felony.

There is no specific Kenyan law on assisted reproduction technologies this being a relatively new area even for the developed countries which are more progressive than us in terms of legal development. This research conducted a comparative study on how other countries have handled certain legal situations that may also be occurring in Kenya or are likely to occur. The study also evaluated whether the current Kenyan laws provide an enabling environment for IVF for women or whether they hinder it and if indeed women's concerns in this area are covered within them.

#### **2.4 Human rights aspects**

Children of gamete donors have a right to information of donors' genetic characteristics, and they may seek to compel disclosure of records of their biological parents' identities. A limit may be that, while this right may require disclosure of an available record, it may not require that information of a donor's personal identity initially be recorded. Similarly, it may not require a possible donor to submit to involuntary DNA testing to show genetic parenthood. Donors' rights to physical integrity protect them against forced donation of samples for DNA testing. However, their rights to private life may not prevail over children's rights to receive information so as to prevent DNA testing of donors' samples legally acquired for those purposes (Cook et al., 2003).

The Economic Social and Cultural Rights Covenant ratified by Kenya in 1976 in article 15.1 provides that States parties to the covenant should recognize the right of everyone to enjoy the benefits of scientific progress and its applications.

The Beijing Platform for Action(1995) paragraph 109(h) states that "Governments should provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable methods for the

regulation of fertility, including natural family planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases." Among others, this research needs to be guided at all stages by users and from the perspective of gender, particularly the perspective of women, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research (Center for Reproductive Rights, 2003).

The above literature confirms that although Kenya does not have any direct law on IVF, Kenya is a signatory to many international conventions and treaties to which she can be held accountable. This study sought information on how the various treaties and conventions can be used to influence legal development as well as a regulatory framework in this area.

## **2.5 THEORETICAL FRAMEWORK**

The theoretical framework for this study draws on postmodern feminist scholarship. Postmodern feminist theories suggest that no universal research agenda or application of technologies will be appropriate and that various women will have different reactions to technologies depending upon their own class, race, sexuality, country, and other factors. In contrast to liberal feminism, postmodernism dissolves the universal subject and the possibility that women speak in a unified voice or that they can be universally addressed (Mamo, 2004).

Postmodernism describes the process whereby certain foundational distinctions or boundaries are breached, leading to a crisis Of legitimacy: this process is occurring, for example, in traditional beliefs about parenthood, procreation, and kinship. Beliefs about procreation are themselves foundational to a range of cultural definitions concerning parenthood and kinship, gender and sexual difference, inheritance and descent. To modify the process of reproduction or genetic inheritance is to make unprecedented interventions into human reproductive futures and thus, inevitably, into key definitions of humanity itself through reproductive assistance, for example, procreation is separated not

only from sexuality but from the body and fertilization is achieved technologically (Franklin, 1995).

From a postmodern point of view, the loss suffered in conflating natural and technological facts need not mean the demise of the natural as a symbolic domain or the loss of its authority entirely. What postmodernism describes is a loss of faith, a crisis of legitimacy, and a collapse of foundational authority. It is a particular construction of nature that is shifting, one that arguably provided a certain degree of reassurance as a source of absolute truth. In the confusion encountered within the law around these contested natural facts is evident a loss of faith in nature as a referent system. It is to this particular loss, not the failure of beliefs about the natural more generally (which appear happily to mutate indiscriminately), that a postmodern character might be ascribed (Franklin, 1995).

Modern legal and political philosophy tend to emphasize the notions of identity (either individual identity in the liberal tradition or identity of the social group in the Marxist tradition), although one of the clearest and most outstanding aspects of our contemporary world is the erosion of traditional forms of personal and social identification: sex, class, race, trade union, the heterosexual family based on monogamy among others. Many, not to say the majority of individuals, function more efficiently outside of those traditional parameters of belonging and they resort to other criteria of identity *ad hoc* (under construction) that are considerably more fluid (de Carmona,1998).

This study adopted the postmodern feminist theory as espoused by Valerie Hartouni in 1997. Valerie Hartouni, writes that the body has become "open to the public," especially the interior space that is the womb, in which the developing foetus is then seen as "housed." It is this visualization of the body that allows us to see the body as a social text, even when it appears to be the most natural or "objective" of objects.

The social nature of reproductive technology is made ever starker by the hearing of contentious cases in courts of law. Here, where reproductive practices enter the legal discourse, we see how notions of property and contract then shape our understandings of

who 'owns' embryos and babies born of surrogacy arrangements. For example, the surrogacy cases that gave legal parameters to the discourse were decided on the basis of contract laws. What was seen as critical was how the money changed hands, what the deals had been, and what had been spelled out in writing. For such confusions, the remedies suggested are better contracts and tougher deals - the definition and naming of the problem as a legal one directs us to legal solutions. Hartouni's insight is that even this primary ordering or arrangement is freighted and, not tangentially, based on a view of women that names them as "fetal containers" (Zoloth-Dorfman, 1998). Hartouni discusses ways of seeing reproduction and how these shape the debates over new technologies of reproduction, often striving to maintain the very social conventions of family that the technologies could possibly overthrow (Ariss, 1997).

This theory is relevant in the study as it explains how different categories of women face different legal hurdles in trying to access assisted reproductive services and how the social stratification within our society influences the development of laws.

## 2.6 HYPOTHESES

From the literature review, the following assumptions were tested which were to be either validated or rejected on the basis of the research findings:

- i) There are no specific laws in Kenya to regulate IVF.
- ii) Legal and regulatory frameworks have a positive influence on accessibility of IVF for women.
- iii) Different women have different experiences with the law depending on social factors such as their class, sexuality and age.
- iv) Legal positions on IVF are determined by the social views of what is an accepted family.

*iIMi <  
7 r , - ' y Of fj , tr*

## **CHAPTER 3:            METHODODOLOGY**

### **3.1     Introduction**

This chapter covers information on research site, sample population and sampling procedures and methods of data collection as well as data analysis. It also covers the anticipated problems within this study and the ethical considerations that were observed in the process.

### **3.2     Research Site**

The research was conducted in Nairobi which is the capital city of Kenya and one of the eight provinces in the Country. Nairobi has a population of about 2,143,254 people with 1,153,828 females and 989,426 males (GOK, 2001). It is cosmopolitan and the heart of most commercial, educational, socio-economic and industrial activities in the republic. It is one of the few towns where *in vitro* Fertilization (IVF) services are currently being offered in Kenya. Nairobi also has 3 IVF treatment facilities being The Nairobi IVF Center, The Nairobi Enhancement Facility Centre within Nairobi Hospital and The Aga Khan Hospital. CBS et al., (2004) report that fertility is lowest in Nairobi province with 2.7 children per woman and highest in North Eastern province with 7.0 children per woman.

The first Kenyan baby born out of IVF in 2006 was in Nairobi. Nairobi is a more suitable site for the study as the informants who are likely to be obtained from the site have had a relatively longer period of time to ponder over the possible legal challenges of IVF. For the same reason, it is also more likely to have a greater number of persons seeking IVF as people are more likely to be aware of these services. Nairobi was also chosen as a result of its convenient location given, the limitations in financial resources and time available to conduct the research.

Nairobi has a greater number of health facilities with more advanced technologies as compared to other towns. In urban areas such as Nairobi, the majority of the population lives within 4 kilometers of a health facility whereas in the rural areas, the distance ranges from 5 to 8 kilometers in the densely populated areas and 20 to 25 kilometers in the arid and semi arid areas (GOK, 1996). Nairobi is serviced by 29 public facilities, namely, 18 dispensaries, 8 health centers, 1 district hospital and 2 national and specialist hospitals (Nyanjom, 2006). Residents of Nairobi are therefore, more likely to access IVF services due to their proximity to the hospitals with wide ranging services on offer.

Nairobi also has the highest number of those with educational attainment above secondary level being at 15.4% whereas North Eastern province records a meager 0.2 % of educational attainment above secondary school. Central Province which follows Nairobi province is only at 5.0% (CBS et al., 2004). The level of education is important in determining the knowledge of the informants on the new reproductive technologies which in turn influences their perceptions on such services. Informants who have exposure to new technologies are more likely to accept culturally unaccepted practices such as IVF and therefore, more likely to use the services than those who have no knowledge of technological advancements in other parts of the world. At the same time, the level of education also determines their financial capacity to access these services.

Access to information is essential in increasing people's knowledge and awareness of what is taking place around them. Nairobi has the highest proportion of women and men who have access to the media (newspapers, television and radio) as compared to other provinces whereas the province with the least access to media is North Eastern Province (CBS et al., 2004).

### **3.3 Research Design**

This was a cross sectional exploratory study which assessed the knowledge, beliefs and perceptions on IVF and sought answers to questions such as how legal factors affect women's access to IVF.

The research sought to gain insight into the problem by investigating people's views on the problem and how they interpret the nature of the problem. The data collection methods used were key informant interviews and narratives. The period for the study was three weeks.

### **3.4 Sample and sampling procedures**

The study used a sample of 20 individuals. The individual was the unit of analysis. The study population included various categories of individuals within the city of Nairobi who all had knowledge or had experience with the subject matter of study. These included women who had undergone or were undergoing IVF or who wished to undergo IVF, doctors and lawyers specialized in the field of study. Women who had undergone IVF or who wished to undergo IVF were interviewed to examine their level of knowledge on the subject matter as well as their experiences and perspectives especially legal on the same. The initial informant was a person personally known to the researcher who had been enlisted for IVF services at Nairobi hospital since 2008.

Purposive and snowball non probability sampling designs were used as the sampling population could not be precisely defined and there was no list of the sampling population available. The initial contact was requested to introduce the researcher to other persons who were seeking or had sought IVF services known to her.

Lawyers and doctors who had experience of practice in reproductive health rights were also interviewed. The researcher interviewed the doctor who provided the services for the first successful IVF baby in Kenya. In depth interviews were conducted with gynaecologists who practise in hospitals that serve as referral points during the pregnancy of the women who have successfully accessed IVF. The researcher also identified and interviewed lawyers who had practiced in the field of reproductive health rights. Contacts for such lawyers were obtained from civil society organizations that work around reproductive health. Purposive sampling was used for expert informants such as doctors

and lawyers with expertise on reproductive health rights. There were 16 interviews on the basis of the purposive sampling.

Snowballing enabled the researcher to find informants who have had first hand experience with IVF. One key individual who had a personal experience with IVF was located and thereafter, asked to assist in getting the other people known to her who have had similar experiences. Although the initial target sample size was 5 individuals, only 4 were reached and interviewed during the time of study. This design was chosen because of the difficulty in finding the study population. The challenge in locating the study population was because, there are not many people with experience on IVF in Kenya as it is a new technology.

Out of the 20 informants, two had used IVF treatment before; one was in the process of using the treatment whereas one was desirous of undertaking the treatment. Four informants were doctors out of which two were directly involved in offering IVF treatment while one helped to manage pregnancies through IVF on referral and one was a gynaecologist conversant with IVF treatment and who was also serving in the government's taskforce on Regulatory Framework for Assisted Reproductive Technology. There was no lawyer who had handled a case related to IVF or who knew of any other lawyer who had handled such a case in Kenya.

### **3.5 Data collection methods**

#### **3.5.1 Secondary sources**

Secondary data based on books, journals, reports, magazines, Government and Non-Governmental organizations materials formed part of the literature review in this study. Secondary data was utilized to supplement the primary data and to aid in the analysis of data collected. Secondary data was used because of the scarcity of information on new reproductive technologies in Kenya. This type of data was also useful for comparative purposes and was thus used to compare the legal challenges in Kenya with other



jurisdictions such as the USA and Australia that are advanced in new reproductive technologies. Secondary information also assisted in determining the themes for primary data collection and formed the core of the reviewed literature.

### **3.5.2 Key informant interviews**

Key informant interviews were held with 16 doctors and lawyers who were knowledgeable in the subject matter of study. The method used structured questions to obtain factual information and open-ended questions to obtain opinions, explanations or descriptions on access and challenges to IVF services. This approach was supplemented with follow-up questions in order to enable clarification of the responses. The questions were determined in advance of the interviews on the basis of the themes already identified from the secondary data collected. Some of the issues determined through this method included discussions on whether there are certain requirements a potential IVF user must meet before accessing IVF and whether the doctors inform their clients before accessing IVF services of the likely legal challenges they may face (see annexure 1). The questions were asked in a clear and non-directive manner in order not to predetermine or lead the answers. The researcher pre tested the interview guide with two informants who qualified to be interviewed under this study. After which, changes were made to the interview guide to ensure clarity and precision of facts.

### **3.5.3 Narrative**

The study gave an opportunity to four individuals who had first hand experience with IVF to narrate their experiences. This covered areas such as the personal experiences of the informants with *in vitro* fertilization and how social factors such as their class, income and age affected their access to the services. They were also asked if they suffered any legal challenges or if indeed it was a consideration before accessing the services.

### **3.6 Methods of data analysis**

The study collected qualitative data which has been analysed thematically and from which conclusions have been drawn as guided by the objectives and hypotheses of the study.

### **3.7 Ethical considerations**

The study obtained informed consent from the informants. They were all requested to sign a written consent form after a thorough explanation of the research topic and process. Anonymity and right to privacy of the research subjects was guaranteed and mechanism was put in place to protect the trust and welfare of the informants. The data has been coded to protect their identity and no name of an informant has been used in the write-up.

The informants were asked at the beginning of the interview if they wished to identify themselves and if the same could be recorded or not. Their permission was also sought to record the interview. They were informed that they did not have to answer every question and that they reserved the right to withdraw from the interview at any time. The explanation to the informants of their rights helped to create a rapport with them. All data collected was kept confidential and will be destroyed at the end of the write-up process.

## **CHAPTER 4: DATA PRESENTATION AND DISCUSSIONS**

### **4.1 Introduction**

This chapter discusses the research findings, interprets and presents the information on the legal challenges of the new reproductive technology in Kenya under the following themes; demographic characteristics of informants interviewed, the perceptions and knowledge of IVF in Kenya, laws and regulatory frameworks in Kenya relating to IVF and psycho social support of IVF patients.

### **4.2 Demographic characteristics of Informants**

The informants in the study were asked to give some general information regarding their sex, age, household status, education and occupation. Out of 20 individuals interviewed 12 (60%) were women whereas 8 (40 %) were men. All of them were in formal employment and had attained college level education and above. The study interviewed 13 (65 %) informants between 25 and 40 years of age and 7 (35%) were above 40 years. 11 (55%) of the informants were married whereas 9 (45%) were single. In terms of the people interviewed, the distribution was as follows: 4 individuals seeking IVF, 4 medical doctors who are specialized in reproductive health and 12 lawyers specialized in reproductive health rights.

The individuals were heterogeneous in terms of sex, education, and occupation. The lawyers formed the highest number of informants due to the fact that the area of study was in their area of expertise and emphasized on the legal challenges of IVF. This heterogeneity of informants is important in helping to achieve a multi-dimensional perspective on the legal challenges of IVF from the users of the services, the providers of the services and the legal experts in the health domain within the Kenyan context.

### 4.3 Perceptions and knowledge of IVF

All the informants felt that IVF was a good technology which assisted those who were unable to reproduce on their own. They however felt that although it is generally good, the treatment raises serious legal, moral and ethical issues which if not addressed created a potential environment for misuse and general human rights abuse. One informant noted that there are certain churches in Nairobi which have embraced this technology such as The Nairobi Pentecostal Church and Winners Church where experts in this area are routinely invited to talk to the congregants about the treatment. The informant observed as follows:

*"Not all churches are opposed to IVF. Churches such as Winners Chapel and Nairobi Pentecostal Church have embraced this technology and have sessions within the services when they invite experts to explain the procedures."*

However, 25% of the informants noted that the Catholic Church is averse to this treatment arguing that it competes with God. One informant who was a lawyer had this to

*"The Catholics are opposed to many aspects of reproductive health rights. They have publicly opposed IVF saying it competes with God. "*

The areas of concern raised by the informants were discrimination in access to the services, stigma directed to the IVF users as well as the children born of it, professional negligence and misconduct by providers and the costs of the services which are exorbitant and out of reach for the majority. In this study, the researcher opines that all the informants found the treatment generally acceptable because the research targeted people who had either used these services or who offered these services or who were generally specialized and knowledgeable in this area and therefore not averse to the technology.

Asked about the understanding of IVF, one informant who was undergoing IVF treatment and who was a graduate and a practitioner within the reproductive health circles stated

*"It is highly scientific and not easy to understand in layman's language until you start going through the process".*

This statement expresses the frustration experienced by users of this service and raises concern that the users may be exploited if they do not clearly understand the processes involved and yet there are no government regulations to protect them.

The informants also raised social concerns to the IVF technology and stated that the technology does not allow a person in certain instances to physically assess and affirm the physical attributes of the person who is going to procreate and further their genes; a factor which is important in the ordinary manner of selecting a partner for procreation within the African context. One informant stated as follows:-

*"IVF would cause problems in the African context as in any relationship, a person wants to consciously assess your physical qualities as to whether you should father or mother their child. "*

The informants also stated that, the new reproductive technologies would make marriages as we know it unnecessary because women can now get children without sexual intercourse which in essence challenges patriarchy and is perhaps the reason for the resistance to it. One informant responding to the question on the concerns which IVF raises stated as follows: -

*"It makes marriages as we know it unnecessary because women can get kids without sexual intercourse and I think this is what the men find threatening; that they may be rendered inconsequential. "*

The other social concern raised by the informants was that the technology raises a crisis of identity for the child as the resultant child may not be biologically related to the birth parents such as in cases of surrogacy where there is a third party in the picture who may

also claim the child. An informant observed as follows on the concerns which IVF raises:-

*"Once people know that's the way you got pregnant, you and the child will be stigmatized as people tend to castigate things they don't understand. The child may also be affected by the lack of clarity as to who his real parents are. "*

Perceptions and knowledge is important in determining the ease of access to IVF services. In terms of the knowledge of IVF providers, 9 (45%) of the informants did not know of any of the institutions that offer IVF services but only knew the name of one doctor (Dr. Noreh) who is known to offer this services and the fact that he had a clinic but did not know where exactly the clinic is located. Six informants knew at least two facilities that offer the services and one informant did not know any health facility that offered the services, whereas four of the informants who were medical doctors knew of five facilities where these services are offered. The five hospitals that offer IVF were listed as Nairobi Hospital Fertility Enhancement Center, The Nairobi IVF Center, Medihill (Eldoret), Aga Khan Hospital and a center in Mombasa. The Nairobi IVF Center was however, noted as the most developed clinic in terms of treatment and offered a range of services not available in the other centers in the country.

Nine (45%) informants stated that IVF costs approximately Kshs. 300,000 per treatment cycle. This was affirmed by one of the doctors who offer this service. Ten (50 %) informants reportedly thought that the costs ranged between Kshs. 100,000 and 200,000 and one informant thought that the cost was Kshs. 20,000.

Regarding the costs of treatment, 85% (17) of the informants felt that the services were too expensive and ought to be regulated by the government. The misconception about the exact cost is very important in determining access because if the public does not know the cost, then they cannot seek these services if they need them. Equally, it may mean that the field is so unregulated that users are exploited and the rates vary according to your location, the doctor attending to you and the provider's view of the client in terms of financial ability or capacity. Further, the cost may also be a clear testimony that the providers are exploiting the vulnerability of the patients given the primacy of child

bearing in most African marriages. The stigma attached to infertility and childlessness may offer the necessary impetus and room for exploitation of the services seekers. Since the informants in this study were individuals selected on the basis of their expertise in this area, their lack of knowledge of the approximate cost of this technology suggests that people generally have no knowledge of their costs.

#### **4.4. Policies, laws and regulatory frameworks**

All of the informants stated that there were no legal or regulatory frameworks on IVF in Kenya and that currently; the environment is a minefield for providers as they operate as they wish.

The informants noted that there are no laws on NRT and also no regulatory frameworks potentially creating an environment for abuse. Resulting from this legal vacuum, 90 % (18) of them felt that this lack of laws and policy is the reason for the high cost of IVF. One informant stated that: -

*"The IVF centres are private and costly and thus exclude many deserving people. The government should come in to regulate the costs so that they are not overcharged. The government should subsidize these costs so that the many deserving poor people are able to access them as they form a majority of the populace."*

An informant who was an expatriate and a provider of IVF in both Kenya and Latvia observed as follows:

*"NRT is regulated in some countries mostly because the government funds them. In countries such as Sweden the government finances the first several attempts for women. This is mainly because population in those countries is declining as people are mostly career oriented and not starting families early or are not getting into families at all. Population in Kenya is high and may explain why Kenya is not keen on issues of infertility and has no regulations on NRT. At the same time, one may explain that there are other pressing issues such as people dying of malaria and IVF may be seen as luxury in Kenya and not a life endangerment situation. But where the government puts its money, it must regulate. "*

Asked why they thought there were no laws or policy on IVF, 25% (5) of them opined that the lack of laws and policy was because of the government's preference for population control measures as opposed to treating infertility which would negate this objective. Another half (50%) of the informants stated that policy and laws on IVF are lacking because it is still a new technology and enactment of legislations usually lag behind technology development. One informant further stated that the government's lack of commitment to treating infertility has been exhibited by its inability to fund the taskforce on Regulatory Framework for Assisted Reproductive Technology, which was created in 2007 with a mandate among others to recommend a regulatory framework for ART in Kenya and to analyse the legal, ethical and moral issues revolving around ART. The position held by these informants has also been confirmed by The Kenya National Reproductive Health Policy which states that infertility is not a priority issue and it ranks low against other perceived pressing issues such as maternal and child health care (MOH, 2007).

In this study, I argue that the lack of policy and legislation on IVF is as a result of the lack of seriousness with which the government treats issues of infertility because the government sees population control as the most viable means of achieving sustainable development. This is evidenced by its lack of funding for matters related to infertility such as the Taskforce on Regulatory Framework for Assisted Reproductive Technology and its National Reproductive Health Policy which expressly relegates infertility to the back street of reproductive health concerns.

This analysis follows the position adopted by Gupta (2000) that Population Control Programmes see women as instruments for managing population growth and reduce women to fertility factors. Gupta further observes that investment in schemes focused on women is propagated to achieve population targets and reduce fertility rates in the context of national developmental goals. That women often find themselves caught between contradictory pressures from the State which propagates that couples have fewer



children, and on the other hand, patriarchal family structures which demand from them that they produce a certain number of children, preferably sons.

Gupta (2000) also notes that access to technologies depends on the existence of public structures and policies to provide them. The values and priorities of society, as expressed through its institutions, laws and funding arrangements, affect individual options and choices.

Following the above analysis, it is therefore possible to conclude that as long as there remain no laws and policies in place to regulate provision of IVF, the number of persons able to access it will remain minimal. It is also a possibility that the government finds itself inadequate to regulate a health concern that it feels ill prepared to provide since health is one of the cardinal responsibilities of governments in Africa.

#### **4.4.1 The Constitution**

All the informants acknowledged that there is no law in Kenya that restricts homosexuals from accessing IVF services. However, they noted that there are several instances in which IVF would not be appropriate. Two (10%) of the informants stated that to offer IVF services to post menopausal women would not be in the best interest of the child for reasons that there would be no one to take care of the child after the demise of the post menopausal mother which would be soon after the birth of the child because of her advanced age; and further that the advanced age may cause the child to be born with health problems. One informant who is a child rights lawyer stated as follows: -

*"Persons above menopause should not be allowed to undergo IVF treatment. This is from a child rights perspective for example what would be the health risks to the baby and who would take care of the baby upon the demise of the elderly mother?"*

The above position was refuted by eight (40 %) of the informants who stated that to refuse to offer these service to women who have attained the age of menopause would be discriminatory on the basis of age and sex. Further, they noted that death of a person is

not predicated on their age and that this argument flies in the face of the realities in all parts of Kenya where the older generation is taking care of their grand children after the death of their children as a result of the HIV/AIDS scourge which has ravaged the country. Thus one informant who is a women rights lawyer stated that:-

*"Even post menopausal women should get such services. Only thing to do is to encourage them to have ability to take care of the child thus health wise and financially. Even now, young mothers are dying and leaving their children to be taken care of by grandmothers so it doesn't matter. This is what HIV/AIDS has done to our society".*

In addition, 15 (75%) informants, mostly females affirmed that it would also be discrimination on the basis of sex where men of similar age are not denied similar services especially because of the belief within various Kenyan communities that men are fit to procreate at any age whereas the society frowns upon the procreation by an elderly woman.

One informant opined that a decision on whether to allow post menopausal women to access IVF treatment should be on a case by case basis with the woman first advancing justifiable reasons as to her late attempt at pregnancy. Two informants acknowledged that the decision whether to offer IVF treatment to post menopausal women is a potential area for conflict but they did not have an opinion on how the same should be treated.

One doctor reported that they would not offer IVF treatment to unpopular partnerships such as homosexuals. Two of his professional colleagues however, stated that they would only provide services as per the hospital policy of the particular facility where they worked at any given time. This raises the concern that there is a possibility that the Hippocratic oath taken by medical practitioners can be varied in accordance with the profit motives of a private clinic which would in turn violate certain rights of the service users.

An analysis of the above responses shows that the lack of laws create an environment where the fundamental rights of persons who are seen not to conform to societal values may be infringed.

According to the Kenyan Constitution, section 82 protects persons from discrimination on grounds of race, tribe, place of origin or residence or other local connection, political opinion, colour, creed or sex whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not subjected (LawAfrica, 2005). There is no Kenyan law which expressly prohibits homosexuality. The Kenyan Constitution does not protect homosexuals because sexuality is not one of the grounds of discrimination from which persons are protected. It is however trite law in Kenya that where there is a lacuna in the domestic laws, then the judges must look for answers in the international conventions and treaties that bind the country. Kenya ratified The Convention on Elimination of Discrimination against Women (CEDAW) in 1984, The International Covenant on Civil and Political Rights (ICCPR) in 1976 and the Covenant on Economic, Social and Cultural Rights (CESCR) in 1976.

The CESCR Committee in its General Comment number 14 proscribed any discrimination in access to health care and the underlying determinants of health, as well as to means and entitlements for their procurement on the grounds of sexual orientation which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (Center for Reproductive Rights, 2002).

The CEDAW Committee has also expressed concern over criminal punishment for homosexuality and has called for the decriminalization of homosexuality. The Committee has also asked that state parties reconceptualise homosexuality as sexual orientation. The CEDAW Committee is also the only committee that has discussed sexual orientation as an affirmative ground for asylum (Center for Reproductive Rights, 2002).

Although Kenya has bound herself by these conventions, the reality on the ground is that provisions such as these are often flouted with arguments being that homosexuality is

immoral and un-African. This is clearly shown by the debate that has characterized the Constitution making process in Kenya to the extent that, The Harmonised Draft Constitution of Kenya expressly provides that the right to found a family only applies to adults of opposite sex. A contradiction is however evident in this draft because, whereas, it provides in section 42 (3) that every adult has the right to found a family, the same draft provides in section 42 (2) that every adult has the right to marry only a person of opposite sex (Committee of Experts, 2009:26) thereby expressly prohibiting homosexuality. This clearly exhibits the difficulty in dealing with the subject of sexuality in the Kenyan society today. Whereas, the Committee of Experts drafting the Constitution are eager to appease the mostly religious section of the society which have strongly opposed gay rights; for expediency and so that the draft can pass through a referendum which would be the second one of its nature for Kenya, the Committee is adopting the less controversial path by outlawing homosexuality. It is however an undisputed fact that in the Kenyan society today like other societies, human sexuality can no longer be divided between two categories only. Therefore if everyone has a right to found a family be they lesbian, gay, transgender, queer, bisexual or otherwise, it follows that they have the rights to achieve familial dreams which may also be done through means other than by marriage such as surrogacy, adoption and fostering among others.

#### **4.4.2 Consent of sperm and egg donor**

When asked whether consent should be sought before sperms or eggs are donated, all the informants stated that the consent of a donor should be sought at all times before donation. The informants stated that to harvest the sperms or eggs of an unconscious person for later fertilization would be unethical and an infringement of their rights to privacy as the consent of the unconscious person would not have been sought. The informants stated that an exception to the general rule may be made where it is shown that the unconscious person was legally married to the donee or that they had been trying to get children.

The Human Tissue Act, Cap 252 of the Laws of Kenya states that any person may in the presence of two or more witnesses during his last illness express a request that his body be used after his death for therapeutic purposes or for research. A person who is lawfully in possession of the body of deceased may authorize the removal of any part of his body if the deceased had not expressed an objection to such use during his lifetime or a surviving spouse has not objected to such use.

The Human Tissue Act is the only Kenyan Law that comes close to providing for cases of donation of this kind although it is also ill fitted to the extent that the donor must actually be dead for this law to apply.

#### **4.4.3 Disposal of unused embryos and reduction of surplus embryos**

During the interview, the informants who provided IVF services were asked how they disposed unused embryos. They indicated that because the procedure is relatively new in Kenya, the first IVF child at their facility having been born in 2006, they were yet to encounter problems with disposal as they had a bank within their clinic where they had been keeping the embryos. They were therefore, not yet overwhelmed with the numbers. They however listed the ways to deal with unused embryos as donation for research, storage for the owners' future use or that they may be destroyed or donated to another couple/IVF client. All the informants stated that the manner in which the frozen embryos are disposed off could potentially raise ethical and legal concerns. Asked whether the state should ban usage of frozen embryos for certain researches, all the informants stated that there should be restrictions on the kind of research which may be carried out using the frozen embryos.

The informants who offered IVF services noted that at their clinics, every patient who registers for this service signs a written consent where they clearly state how they would wish their unused embryos to be disposed off. This is however, not a legal requirement and it is possible for a couple to undergo this procedure without having signed a contract on how the unused embryos would be disposed off. In cases where a couple commissions

IVF and the couple subsequently develop problems in their relationship; if either of the couple no longer wants the embryo implanted as he no longer wants to have a child with the other party and yet, the other party is still desirous of having the embryo for her own use despite their relationship problems; these would raise legal challenges which would have to be addressed in a court of law. In such cases, the court may look at the letter and spirit of the contract signed by both prior to the treatment. However, most people going for IVF appear desperate for a child and like a patient in a hospital before a doctor that is supposedly meant to save your life; you may end up dotting lines that are in themselves not based on informed consent.

All the informants stated that disposal of unused embryos (after fertilization but before implantation) should not be construed as abortion because the embryo in this case is actually outside the body and yet the Penal Code requires that a woman be pregnant with child in order for its termination to amount to abortion.

They further argued that the disposal cannot constitute abortion as the embryos are from the start predisposed to be disposed. Similarly, that the reduction of surplus embryos in cases of multiple pregnancy (after implantation of embryos) cannot amount to abortion because in the case of an abortion, a woman no longer remains pregnant but where surplus embryo is reduced, it improves the chances of those fetuses left and the woman still remains pregnant, but an abortion would result in total elimination of pregnancy. At the same time informants also stated that reduction of surplus embryos would not be an abortion because the same is usually done for the health benefit of the mother and the remaining embryos. Embryo reduction reduces likelihood of complications related to multiple pregnancies such as high blood pressure. The Kenyan Penal Code does not criminalise the procurement of abortion which is done for health reasons of the mother.

#### **4.4.4 Surrogacy contracts**

Two informants who were doctors reported having had clients who were party to a surrogacy arrangement in Kenya. When asked the likely legal challenges which would be

caused by surrogacy arrangements in Kenya, the informants listed them to include cases where the surrogate mother is a minor and where the surrogate host alleges undue influence or coercion.

In most cases the surrogate mother agrees to be part of this arrangement for a fee but there are also certain agreements without financial benefits. Surrogacy agreements intend that the genetic mother will also be the nurturing mother after the child's birth and that the surrogate mother will only function as a carrying mother and surrender the child immediately after birth to the nurturing mother. The informants noted that legal suits may arise in surrogacy cases, where, the genetic mother or parents change their minds during pregnancy and the surrogate mother wishes to keep the child after birth, or both mothers might wish to abandon the child and the nurturing mother would then be a third woman. These cases may amount to infringement of child's rights under the Children Act and the parents may also be sued for child neglect and abandonment.

The Children Act is however not clear whether it would be the genetic parents or the surrogate mother who would be culpable in this case. The surrogate mother may sue the genetic parents for breach of contract if they refuse to take the resultant child. The genetic parents may also sue the surrogate mother for breach of contract if she refuses to hand over the child to them. The legal problems arising from surrogacy agreements may be further complicated by the presence and involvement of commercial agencies. The informants also noted that legal dispute may arise when a contracting couple refuses to accept a child born from a surrogacy arrangement if the child is handicapped and this dispute may invoke the Children Act where the principle of the best interest of the child would determine parental responsibility and the placement of the child. At the same time, the court may decide to lay emphasis on the content of the Contract and see if the same had been provided for in the Contract or not.

Complication may arise from surrogacy arrangements because of the fact that the medical records of a baby at birth such as the birth notification is often in the name of the surrogate mother as she is the one who delivers the baby and our structures do not recognize the possibility of the biological mother being different from the birth mother.

This situation is compounded by the fact that most of the IVF Centers only offer their services up till the time when the woman is pregnant and then she is referred to an ante natal clinic elsewhere. In such situations, different providers become the managers of her progress without any follow up by the IVF providers. In such cases, the hospital where the woman delivers is not privy to the surrogacy arrangement and the fact that the woman is only a host mother and not the biological mother. Therefore, for all intents and purposes, the surrogate mother would be reflected in the hospital and hence government records as the mother and the only way to regularize this anomaly would be if the biological mother legally adopts the child.

Asked how disputes in cases of surrogacy would be resolved where the surrogate mother changes her mind about giving up the child, 18 informants stated that the letter and spirit of the contract they had entered into would be used to resolve this dispute. They observed that the surrogate mother should not be allowed to keep this child as the intent from the onset was never for her to keep it. Two informants however, noted that the surrogate mother may develop certain attachments to the child which should not be ignored and that the courts should make arrangements where the surrogate mother is allowed some limited contact with the child. In such cases, Gupta (2000) observes that to force the woman to give up the child to the contracting party is to accept biological essentialism that justifies traditional female roles, the sexual division of labour. Thus, to put the bond between mother and child on the level of contract law denies the personhood of women, contributing to their dehumanization.

Given the above scenario, the researcher is of the view that surrogacy arrangements should be allowed by law but there should be limits within which they can operate as they are potentially exploitative of women. These contracts perpetuate division of women along economic classes where those with high income exploit those who can barely meet their needs and must in turn enter these arrangements for their survival. The pressure upon the women is compounded by the role played by women in the Kenyan society where the society expects them to be the ones to make the ultimate sacrifices for their families when their families fall short on their needs such as food and medical provisions.



This analysis has been informed by the positions held by Corea (1984) and Mies (1988). Corea notes that surrogacy agreements inevitably involve structural class inequalities between the parents who 'order' the child and the mother who bears it. Under capitalism, new freedoms can also lead to new forms of exploitation of working class and poor women. Surrogacy is exploitative, alienated labour, exploiting women as 'breeder women' (Corea, 1984).

Mies (1988) observes that surrogacy is a new piece of 'work industry' which functions analogously to the exploitation of women whose labour at home is contracted. This has become clear in surrogacy contracts, particularly in America which is a consumer society in its ultimate form. The woman is paid not for the service but for the product which has to be of good quality. Contracting parents require the birth of a healthy baby. There is a social and psychological selection of the woman, to determine if she is a fit person. Also, there is an enormous control over the daily life of the surrogate mother. Once she is pregnant for a commissioning party, she is made to undergo frequent medical check-ups and prenatal diagnosis for genetic screening of the embryo, as the product she is supposed to deliver must be perfect. In case there is something wrong with the foetus, the commissioning couple would decide if she should have an abortion. If the baby were born dead, she would get only a minimal amount, not full payment, because she would not have delivered the goods.

The researcher also holds the view that the development of legal jurisprudence in many countries has opted for an easier way of solving surrogacy disputes for fear of opening up possibilities which challenge the conventional way of looking at families. This is why the courts treat surrogacy more like adoption and will not recognize the possible bond that the surrogate mother may have developed with the offspring or the fact that the resultant child may want to know and have ties with the surrogate mother. According to these judgments, since a host mother has been paid for her services, her said services will be terminated upon the delivery of the good which is the child, after which, she is expected to disappear from the scene. It is interesting and a contradiction that genetic link should

be viewed as stronger and worthy of more protection than social links in a country where a biological father of a child born out of wedlock cannot be forced to maintain his child unless he so wishes or if he co-habited with the mother for twelve months. Yet by the same token of the Children Act, a step father who has been maintaining a child can be legally made to continue providing for the same, thereby creating the impression that there are instances where social connections are recognized by law. There may however, be situations where the resultant child may want to know the mother who carried her/him for the nine months and that such a claim would be legitimate for the reason that the child was never a party to the contract and indeed did not give up any right. While this should not be the case in each surrogacy arrangement, an exception should however, be provided for where a request has been made by the child and the surrogate mother is agreeable.

#### **4.4.5 Best interest of the child**

Twelve of the lawyers interviewed indicated that The Children's Act is insufficient and does not expressly cover the issues that relate to IVF and children born of IVF. The other eight informants without the legal background were unsure of the sufficiency or lack thereof of the Children's Act as relates to IVF. The latter is attributable to the fact that these informants were not lawyers and therefore not conversant with all the details of the legislation.

When asked if children born out of frozen embryos, in cases where the implantation took place years after death of one of the parents, should inherit from the estate of the deceased parent, all the informants stated that the Succession law should expressly recognize the rights of the child to inherit as long as the child is genetically connected to the deceased for example where the couple had frozen embryo and the wife implants that embryo long after his death. The fact that they preserved the embryos in his lifetime is indicative of his intention to have children at some point which therefore, makes them legitimate children who should be able to inherit.

The Law of Succession (Chapter 160 of the Laws of Kenya) states that a child shall include a child conceived but not yet born (as long as that child is subsequently born alive) and, in relation to a female person, a child born to her out of wedlock, and in relation to a male person, a child whom he has expressly recognized or in fact accepted as a child of his own or for whom he has voluntarily assumed permanent responsibility. A look at this definition reveals unequal treatment of men and women by the law, where it is assumed that a woman should only have a biological connection to a child and not a social one in order for the child to benefit from her estate. With regard to a male person, the law does not lay much emphasis on the biological connectedness but more of whether the deceased has recognized and accepted the child as his own. Although the Succession Act in itself allows for equal share of inheritance between daughters and sons, this definition demonstrates the inherent contradictions within our laws which are characterized by our patriarchal values and beliefs.

When asked about the status of legitimacy of a child born out of frozen embryos, all informants stated that such a child would be legitimate child of both parents if born within an existing union. When asked what the status of the same child would be if the frozen embryo was implanted in a woman after divorce or death of the partner, all the informants stated that in cases of death, the child would legitimately belong to the deceased. 95% of the informants felt that a woman should not be allowed to implant in herself the embryos which were frozen when in a marriage after the dissolution of that marriage even though the initial intent was to do so as this would infringe on the partners right to found a family which includes the right to end it.

The Evidence Act (Chapter 80 of the Laws of Kenya) states that the fact that any person was born during the continuance of a valid marriage between his mother and any man, or within two hundred and eighty days after its dissolution, the mother remaining unmarried, shall be conclusive proof of the legitimacy of the child. This law presupposes that children will be conceived only in the natural way where the biological mother will get pregnant and deliver after nine months of the dissolution of the marriage and that this will be a conclusive test of legitimacy of the child. With IVF, it is now possible that a frozen

embryo of the commissioning couple may remain frozen for even longer than five years and this may be after the dissolution of the marriage and yet when the same is implanted, it will still genetically belong to the couple. An informant observed as stated below: -

*"With these technologies, it is possible for an embryo to be frozen for many years. The intention at time of freezing is clearly to have children.. So there is need to amend the laws to reflect these possibilities. "*

The Evidence law assumes that if a child is born within a valid marriage then that shall operate as proof of legitimacy, whereas, it is possible that a married woman may serve as a surrogate host for another couple or person and the same may be without any form of agreement with her husband so that the child that is born is not genetically related to her or her husband and even then, without his consent. This also raises a question as to whether a husband whose wife has entered into a surrogacy agreement with a third party to serve as a surrogate host without his knowledge or consent has any recourse in law. One informant opined as follows: -

*"A married woman should not be allowed to enter a surrogacy contract without the husband's consent because this would be in conflict with her wifely duties like she cannot during the surrogacy arrangement, bear children in their union. "*

Under the current laws, the only recourse a husband may have when his wife enters a surrogacy arrangement without his approval may only be to sue for dissolution of the marriage on grounds of cruelty arguing that this said action has caused him emotional anguish and any other kind of cruelty he may have suffered. The husband may also allege adultery as a ground for divorce as one of the tests for adultery is that the woman is pregnant with child outside the marriage. However, complications would arise as the woman would attest that she never had sexual intercourse with any one so as to constitute adultery. This situation is even complicated more where the surrogate host is pregnant with sperms of an anonymous donor and she only knows the biological mother with whom she entered into the contract so that you cannot pin her down for adultery.

Asked whether in cases where an embryo has been donated for use by a third party, the child subsequently born can request and legally enforce the right to know his/her genetic

parents, seven informants stated that this is a right of the child enforceable under The Children Act and the best interest of the child would be the overriding principle in determining such a dispute. However, nine informants thought that it would not be ideal to disclose the genetic parents and any information the child may want for example pertaining to their health ought to have been acquired from the records by the social parents at the time of acquisition of embryo. In the same breadth, four informants did not have any opinion on how to deal with this problem.

The above cited laws of Kenya mirror the confusion encountered in the use of nature as a referent point when technology challenges that very nature as we know it today. In these cases, these laws fail to recognize the advances so far made by technology. Our laws are also a contradiction to the extent that they purport to protect families when they live within the same household but help to scatter any attempt by women to recreate a semblance of a family when the men are reluctant. This can be seen when the law forces a man to provide maintenance for his step child in cases where he has previously cohabited with the mother but conversely, a man who has fathered a child does not automatically acquire parental responsibility over the child but instead the law bestows such responsibility to the mother in the first instance and only to the man if he is agreeable. It is only through judicial activism that we have seen judicial officers widen the interpretation of the best interest of the child to force all parents to have parental responsibility over their children. Therefore, the woman unlike the man can at no time refuse to maintain her child.

#### **4.5.0 Psycho-social support**

All the service providers interviewed stated that they offered pre-treatment counseling and post treatment counseling which helped the patients to make informed choices on the treatment.

Asked whether they discussed the legal issues of IVF with the patients prior to treatment, all the service providers stated that they brushed through it but did not discuss anything in

detail since there are no legal provisions to guide the discussion. None of them referred their clients elsewhere to seek legal advice before seeking IVF services. When asked whether their doctors discussed the legal implications of IVF with them prior to enrolment for IVF treatment, the informants who had been IVF patients noted that their doctors did not discuss any legal issues with them prior to enrolment for IVF. All of them noted that during the time when they undertook the IVF treatment, at no time did their doctors discuss with them any legal issues. One informant observed that:

*"My doctor did not explain to me the legal position of IVF in Kenya. They only gave me consent forms and explained only the medical issues. Even the consent form they gave me to fill was more to protect the doctor from any form of liability but not to protect the patient. "*

However, all those informants who had undergone IVF treatment noted that they had not had any legal problems following the IVF procedure. They all confessed that they had not given any thought to the likely legal challenges. They all reported an emotional rollercoaster during that time characterized with a lot of anxiety, emotional anguish, physical pain and fatigue. An informant who had made two attempts at the treatment but was still unsuccessful felt that the burden placed on her by society to bear a child was greater than that placed on her husband and that after two failures with the treatment; her husband had become moody and unsupportive. The informant had this to say:

*"I have tried this treatment twice and failed but I have not given up. My husband no longer wants to talk about it even though I feel that the talking would relieve some of the stress I feel. I think I will go ahead and plan for the third attempt on my own. "*

The informants noted that they had been placed under many restrictions such as being on a certain diet, restricted from walking too fast and directed to avoid bending; all of which were to improve their chances of success. Although the restrictions were cumbersome and limiting, they acknowledged that the end justified the means and they were therefore, willing to go through the process at whatever cost. This attitude could be attributed to the fact that the IVF clients finally realized their desire for a child because they had failed in other means. This implies that the goal to get a child far much outweighs any other

consideration be it economic, social, physical and emotional burden. This fits well with the African thinking of marriage being primarily meant for procreation and any couple without a child is seen as a failure and is ridiculed. It also fits well with the infertility thinking in which the entire burden is borne by women and they become the sole bearers of childlessness in most situations.

## **5.0. CONCLUSIONS AND RECCOMENDATIONS**

This section of the project provides the conclusions from the research and recommendations on the best way forward. It is noted that the whole NRTs require legal regulations or else, we may face an avalanche of litigations as the methods become more available to a wider cross section of society.

### **5.1. Conclusions**

The result of this research provides important information on legal challenges of NRTs and how they affect the society as a whole. Despite the limitation of the number of experts knowledgeable in this area, a diverse group of lawyers, doctors and IVF patients were reached and they provided useful information that can be used to develop policy and guide legislation and also to inform the development of jurisprudence in this area.

Generally, the data obtained indicates that there is no explicit law or policy framework on NRTs in Kenya but that there are pieces of legislations and international norms that may be used to address certain types of legal disputes should they arise before enactment of a comprehensive law although the same is not adequate.

The study found that people generally do not have information on IVF treatment, where to access it from, and the potential legal challenges a person may suffer having used this treatment. This lack of knowledge serves to restrict its usage.

The data also indicates that the use of NRTs takes place within the framework of ideologies and policies such as the ideology of motherhood and policies of population control which serve to either promote or hamper wide usage of this treatment.

From the data obtained, it is also clear that the treatment is too costly and out of reach for many deserving infertile Kenyans; a factor which has also limited its usage.



The study also found that women bear the greatest social, physical and emotional pressure as a result of the treatment. These pressures are largely unacknowledged by their families who remain oblivious to the sufferings and thus unsupportive.

The data obtained from the study also indicates that in the absence of legislation and policy on IVF, service providers resort to their own discretion in deciding who qualifies for this service. This discretion is sometimes exercised in a biased manner.

## **5.2 Recommendations**

This study has applied its key findings to develop recommendations which may be used to inform policy formulation on IVF and may also form the basis for further research.

- The government should come up with a policy on the new reproductive technologies.
- The government should enact a specific legislation on new reproductive technologies.
- Parliament should amend all legislations to be in line with the new reproductive technologies.
- The various line ministries should put in place regulations and guidelines around the new reproductive technologies
- Further research is needed on the socio economic aspects of the new reproductive technologies in Kenya which this study has not looked at.
- There is need for a general awareness of the public on IVF, its availability, implications, cost and possible effects.
- The government should be lobbied to subsidize the cost of IVF to make it more affordable to those deserving but are unable to meet the high expenses.

In a nutshell, there is also need for a change of attitude from our conservative cultural definitions of procreation, paternity and maternity to a more inclusive technologically expanded view currently in place the world over.

## BIBLIOGRAPHY

Ariss, R. (1997). Fetal Attraction. A Review of *Cultural Conceptions: on Reproductive Technologies and the Remaking of Life*, by V.S. Hartouni. Available at <http://www.chass.utoronto.ca/epc/srb/srb/fetal.html>. Accessed on 26/3/2009.

Anderssen, N., C. Amlie and E. A Ytteroy E. A (2002). Outcomes for Children with Lesbian or Gay parents: a review of studies from 1978 to 2000. *Scandinavian Journal of Psychology* 43:335-51

Babbie, E. (1995). *The Practice of Social Research*, 7<sup>th</sup> edn. Belmont: Wadsworth.

Bailey, D.K. (1987). *Methods of Research*. New York: The Free Press.

Benard, H.R. (2000). *Social Research Methods*. London : Sage.

Beijing Platform for Action (1995). Report of the Fourth World Conference on Women in Beijing held from 4<sup>th</sup> to 15<sup>th</sup> September 1995. Available at <http://www.un.org/womenwatch/daw/Beijing/platform>. Accessed on 5/1/2009.

Braude, P. & Rowell, P. (2003). *Assisted Conception. 11-In Vitro Fertilization and Intracytoplasmic Sperm Injection. A Clinical review*. Guy's and St Thomas's assisted Conception Unit, London. Available at <http://www.bmi.com/cgi/content/full/327/7419>. Accessed on 28/1/2009.

Carmeli, B. and Dirnfeld, M. (2008). In Vitro Fertilisation Policy in Israel and Women's Perspectives: The More the Better? *Reproductive Health Matters*, 16(31): 182-192.

Center for Reproductive Rights (2002). *Bringing Rights to Bear: An Analysis of the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. New York: Center for Reproductive Rights.

Center for Reproductive Rights (2002). *Bringing Rights to Bear: An Analysis of the work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. New York: Center for Reproductive Rights.

Center for Reproductive Rights (2003). *Reproductive Rights are Human Rights*. New York. New York: Center for Reproductive Rights.

Central Bureau of Statistics (CBS) (Kenya), Ministry of Health (MOH) (Kenya) and ORC Macro 2004. *Kenya Demographic and Health Survey 2003*. Calverton, Maryland: CBS, MOH and ORC Macro.

Cook, R.J., B.M. Dickens and M.H. Fathalla (2003). *Reproductive Health and Human Rights*. New York: Oxford University Press.

Cook, R.J. and Ngwenya, C.G. (2006). Women's Access to Health Care; The Legal Framework. *International Journal of Gynecology and Obstetrics*, 94: 216-225.

Corea, G. (1984). *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper and Row.

Committee of Experts (2009). *Harmonised Draft Constitution of Kenya*. Nairobi: Committee of Experts.

Daar, S. Abdalla & Merali, Z. (2002). *Infertility and assisted Reproductive Technologies in the Developing World*. Available at <http://www.who.int/reproductive-health/infertility/5.pdf>. Accessed on 5/2/2009.

Dawson, S., L. Manderson & V. Tallo (1993). *A Manual for the Use of Focus Groups: Methods for Social Research in Disease*. Boston: International Nutrition Foundation for Developing Countries.

De Carmona, Bozo (1998). Toward a Postmodern Theory of Law. A paper delivered at the Twentieth World Congress on Philosophy, Boston, Massachusetts August 10-15, 1998. Available at <http://www.bu.edu/wcp/Papers/Law/LawBozo.htm>. Accessed on 25/3/2009.

De Melo- Martin, Inmaculada (1998). *Ethics and Uncertainty: In Vitro Fertilisation and Risks to Women's Health*. Available at [www.piercelaw.edu/risk/vol.9/summer/demelo/pdf](http://www.piercelaw.edu/risk/vol.9/summer/demelo/pdf). Accessed on 12/1/2009

Dickens, B. (2008). Legal Developments in Assisted Reproduction. *International Journal of Gynecology and Obstetrics*, 101: 211-215. Available at <http://ssm.com/abstract=1263903>. Accessed on 5/2/2009.

Family Health International (2004). *Sample Focus group Discussions and In depth Interview Guides: Community Awareness of and barriers to Longer-Acting and Permanent Contraception*. Available at [http://www.maqweb.org/iudtoolkit/countTv\\_cases/fgdguide.pdf](http://www.maqweb.org/iudtoolkit/countTv_cases/fgdguide.pdf). Accessed on 1/4/2009.

Floyd, D. and Franklin, S. (2005). *On Reproduction*. Available at <http://www.davis-floyd.com/userfiles/Qn%20Reproduction.pdf>. Accessed on 25/5/2009.

FIGO (2006). *Ethical Issues on Obstetrics and Gynecology*. Available at <http://www.figo.org/files/figo-corp/docs/ethics%20Guidelines%20English%version%202006%20-2009.pdf>. Accessed on 26/3/2009.

Franklin, S. (1995). *Postmodern Procreation: A Cultural Account of Assisted Reproduction*. Available at <http://www.cas.butfalo.edu/classes/dms/berna/dms434/readings/franklin.pdf>. Accessed on 26/3/2009.

Frankford. Nachmias, C. and Nachmias, D. (1996) *Research Methods in the Social Sciences*, 5<sup>th</sup> edn. London: St. Martin's Press.

Frith, M. (2002). Law and Policy Round Up. In M. Berer (Ed.). *Reproductive Health Matters*, 10 : 187-191.

Gilling-Smith C., J. Richard Smith, and A. Semprini (2001). HIV and infertility: time to treat: *British Medical Journal*, 322: 566-567. Available at [www.bmj.cgi/content/full/322](http://www.bmj.cgi/content/full/322). Accessed on 30/1/2009.

Gitonga, M.M., S.J. Kimaiyo and J.J. Mamlin (2004). HIV discordant couples - a rural Kenya experience. Paper presented at the International Conference on AIDS, Bangkok, Thailand from 11 to 15 July, 2004.

Giwa-Osagie, O.F. (2002). *ART in Developing Countries with particular Reference to Sub-Saharan Africa*. Available at <http://www.who.int/reproductive-health/infertility/6.pdf>. Accessed on 5/2/2009.

Government of Kenya (1985). The Penal Code, Chapter 63 of the Laws of Kenya. Nairobi: Government Printer.

Government of Kenya (1989). The Law of Evidence, Chapter 80 of the Laws of Kenya. Nairobi: Government Printer.

Government of Kenya (1996). *National Reproductive Health Strategy, 1997-2010*. Nairobi: Government Printer.

Government of Kenya (2001). *The 1999 Population and Housing Census*, Vol.1. Nairobi: Government Printer.

Government of Kenya (2002). *The Children Act, 2001*. Nairobi: Government Printer

Government of Kenya (2007). *Taskforce on Regulatory Framework for Assisted Reproductive Technology*. Kenya Gazette Notice. Vol. CIX No.3 2-4<sup>th</sup> May 2007. Nairobi: Government Printer.

Gupta, J. A. (2000). *New Reproductive Technologies, Women's Health and Autonomy: Freedom or Dependency?* New Delhi: Sage Publications

Hartouni, V.S. (1997). *Cultural Conceptions: On Reproductive Technologies and the Remaking of Life*. Minnesota: University of Minnesota Press

International Federation of Gynecology and Obstetrics (1996). *Recommendations on Ethical Issues in Obstetrics and Gynecology*. Available at <http://www.rodicovstvo.sk/figo-x.htm>. Accessed on 25/3/2009.

LawAfrica (2005). *Constitution of Kenya*. Nairobi: Law Africa.

Malley, S.P.O. (2000/ *In Vitro Fertilization: Ethical Implications and Alternatives*. Kochi, Japan. Available at [http://www.lifeissues.net/writers/oma/oma\\_01\\_invitro.html](http://www.lifeissues.net/writers/oma/oma_01_invitro.html). Accessed on 22 August 2008.

Mamo, L. (2004). *Theorizing Gender, Sexuality and Medical Technologies: Feminist Approaches to Assisted Reproduction and Lifestyle Drugs*. A paper presented at the Annual Meeting of the American Sociological Association, Hilton, San Francisco and Renaissance Pare 55 Hotel. Available at <http://www.allacademic.com/one/www/research>. Accessed on 30/1/2009.

Mies, M. (1988). From the Individual to the Individual: In the supermarket of 'reproductive alternatives'. *Issues in Reproductive and Genetic Engineering*, 3: 225-37

Mwaura, K. (2007). Why every couple deserves a bundle of joy. In Business Daily of 12 September 2007. Available at [www.bdafrica.com/index2.php?option=com\\_content & task=view & id=29788&pop=1&page=0&itemid=5822](http://www.bdafrica.com/index2.php?option=com_content&task=view&id=29788&pop=1&page=0&itemid=5822). Accessed on 22/8/2008.

Ministry of Health (2007). *National Reproductive Health Policy*. Nairobi: Government Printer

Nyanjom, Othieno (2006). Inequality in Kenya's Health Sector. *Readings on Inequality in Kenya: Sectoral Dynamics and Perspectives*. Nairobi: Society for International Development. Pp. 97-155.

Oki-Ombaka, Ooko (1989). The Kenya Legal System and the Woman Question. In M. Adhiambo & O. Oki-Ombaka (Eds.). Women and Law in Kenya Pp 31-39. Nairobi: Public Law Institute.

Onyango-Ouma, W., H. Birungi and S. Geibel (2005). Understanding the HIV/STI Risks and Prevention Needs of Men Who Have Sex with Men in Nairobi, Kenya. *Horizons Final Technical Report*. Washington, D.C: Population Council.

One World Nations Online, *Map of Nairobi*. Available at [http://www.nationsonline.org/oneworld/niap/google\\_map\\_Nairobi.html](http://www.nationsonline.org/oneworld/niap/google_map_Nairobi.html). Accessed on 18/12/2009

Paterson, M. M. (2005). Assisted Reproductive Technologies and Equity of Access Issues. *Journal of Medical Ethics*, 31: 280-285. Available at <http://jme.bmi.com/cgi/econtent/full/3175/280>. Accessed on 30/1/2009.

Pennings, Guido (1999). Measuring the Welfare of the Child: In Search of the Appropriate Evaluation Principle. *Human Reproduction Journal*, 14(5): 1146-1150. Available at <http://humrep.oxfordjournals.Org/cgi/content/full/14/5/1146>. Accessed on 30/1/2009.

Porter, D. (1997). The Regulation of In Vitro Fertilisation: Social Norms and Discrimination. *Murdoch University Electronic Journal of Law*, 4(3). Available at <http://www.murdoch.edu.au/elaw/issues/v4n3/port43.html>. Accessed on 11/2/2009.

Ritzer, G. (Ed.). (2006). *Blackwell Encyclopedia of Sociology*. Available at [http://www.blackwellreference.com/public/tocnode?id=978140512433\\_1\\_chunk\\_g97814](http://www.blackwellreference.com/public/tocnode?id=978140512433_1_chunk_g97814). Accessed on 26/5/2009.

Sgambati, S. (2007). *Conceiving Mothers: How Access to New Reproductive Technologies and Abortions Construct Motherhood*. Unpublished MA Thesis, Gender and Cultural Studies Program, Simmons College of Arts & Science. Available at [dspace.nitle.org/bitstream/10090/7330/1/Sgambati.doc](http://dspace.nitle.org/bitstream/10090/7330/1/Sgambati.doc) Accessed on 5/2/2009.

Sedlenieks, Klavs (1999). New Reproductive Technologies: Towards Assisted Gender Relations. An Essay for MPhil Degree, Department of Social Anthropology, University of Cambridge. Available at [www.AnthroBase.com](http://www.AnthroBase.com). Accessed on 30/1/2009.

Steinberg D.L. (1997). A Most Selective Practice: The Eugenic Logic of IVF. *Women's Studies International Forum*. 20:33-48

The Women's Health Council, *Position paper on Assisted Human reproduction: The Health and Social Implications for Women*. Dublin, Ireland. Available at [www.whc.ie/publications/position\\_reprod.html](http://www.whc.ie/publications/position_reprod.html). Accessed on 1/8/2009.

UNAIDS (2000). *Guidelines For Studies of the Social and Economic Impact of HIV/AIDS*. Geneva, Switzerland: UNAIDS.

Waithaka, W. (2008). "Fertility Treatment Not Accessible to All," In Business Daily of 12 September 2007. Available at [www.bdafrica.com/index2.php?option=com\\_content & task=view & id=29788pop =1 &page=0&itemid=5822](http://www.bdafrica.com/index2.php?option=com_content&task=view&id=29788pop=1&page=0&itemid=5822). Accessed on 22/8/2008.



WHO (1992). *Recent Advances in Medically-Assisted Conception: Report of a WHO Scientific Group*. WHO Technical Report Series 820. Geneva: WHO.

Zoloth-Dorfman, L. (1998). *Our Bodies, Our cells: Feminist Ethics and the New Reproductive Technology*. Available at <http://womenst.library.wisc.edu/fc/fczoloth.htm>. Accessed on 26/3/2009.

## ANNEXTURE1

### KEY INFORMANT INTERVIEW GUIDE

My name is Evelyne Opondo and I am a student at the University of Nairobi undertaking a research on the legal challenges of the new reproductive technologies. The research aims at examining the legal issues around IVF in Kenya which either hamper or promote an individual's access to these services. With your permission, I would like to record our interview as it will help me better focus on our conversation [pause for response; if subjects says no, then interview will not be recorded].

Please note that you do not have to answer every question. This interview will be kept strictly confidential and your identity will remain anonymous when I write-up the results of the study. Upon completion of the study, all records that contain personal identifiers will be shredded. This interview will take approximately one hour.

Do you agree to be interviewed?

**Name:**

**Date**

<b>ID Code</b>	
<b>Date</b>	
<b>Time</b>	
<b>Interviewer</b>	
<b>Interview Length</b>	

#### Basic Demographic Questions

<b>Age</b>	
<b>Sex</b>	
<b>Household Status &amp; Size</b>	
<b>Education</b>	
<b>Occupation</b>	

#### Perceptions and Knowledge of NRTs

- Have you heard about the new reproductive technologies? *(if participant is unfamiliar with NRT, explain what it is and how it works)*
- Do you have any experience with the new reproductive technologies?
- How do you feel about the new reproductive technologies?

- What do people like about the new reproductive technologies?
- What concerns people about new reproductive technologies?
- Approximately how much does it cost to access NRT services in Kenya?
- Are you familiar with any of the institutions that offer NRT services in Kenya?
- What sorts of problems do men and women have in accessing NRTs? (*Possible probes: Do they always access NRTs on demand? Are there factors that prevent them from approaching the service providers? Have any of your clients, friends, relatives or acquaintances had problems with NRT? Are there gaps? Are specific groups undeserved or unfairly treated?*)

### **NRTs and the Law**

- Are you conversant with any existing regulatory frameworks in Kenya on NRTs? If so, how do they affect men and women? (*Possible probe: whether they affect men and women differently*).
- Are you conversant with any laws in Kenya which relate to NRTs and how they affect men and women (*possible probe: whether they affect men and women differently*).
- Do you tell your clients who are seeking NRT about the possible legal challenges to it?
- Are there any requirements clients must meet before accessing IVF?
- In your experience with NRT, are you aware of any challenges with ;
  - a) the legal status of the resulting child
  - b) determination of the best interest of the child
  - c) consent of gamete/embryo donor
  - d) disposal of unused embryos
  - d) conflict with professional ethics
  - e) any other conflict with the law

*{if participant is unfamiliar with these concepts, explain them before response}*

### **Closing**

Anything else I should be aware of in developing a picture of the challenges of the new reproductive technologies?

Anyone else I should talk to?

Thank you very much for participating in this study. I appreciate your taking the time to talk to me.

**ANNEXTURE 2**  
**NARRATIVE GUIDE**

My name is Evelyne Opondo and I am a student at the University of Nairobi undertaking a research on the legal challenges of new reproductive technologies. The research aims at examining the legal issues around IVF in Kenya which either hamper or promote an individual's access to these services. With your permission, I would like to record our interview as it will help me better focus on our conversation [pause for response; if subjects says no, then interview will not be recorded].

Please note that you do not have to answer every question. This interview will be kept strictly confidential and your identity will remain anonymous when I write-up the results of the study. Upon completion of the study, all records that contain personal identifiers will be shredded. This interview will take approximately one hour.

Do you agree to be interviewed?

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Name: (optional)</b>	
<b>Age:</b>	
<b>Sex:</b>	
<b>Place of residence:</b>	
<b>Education:</b>	
<b>Occupation:</b>	
<b>Income:</b>	
<b>Household status &amp; size;</b>	

- a) Tell me what you know about NRTs?
- b) How did you learn about /discover NRTs?

- c) Describe your experience with NRTs? (Possible probes on concerns about NRTs, cost of accessing such services and what people like about NRTs).
- d) How did you reach the decision to seek NRT services? (Possible probes on who made or assisted in making the decision? Whether husband, mother-in-law, religious or community leaders? Co-wives or others?)
- e) Are you conversant with any existing legal requirements relating to NRTs in Kenya? (Possible probe: whether they affect men and women differently).
- f) Before enrolling for these services, did your doctor or any one else explain to you the possible legal challenges? Were you offered any psycho-social support?
- g) In seeking the IVF services, did you use
  - I) a surrogate mother?
  - II) egg donor?
  - III) sperm donor?
  - IV) the couple's eggs and sperms?(Possible probes: whether any challenges to that arrangement have so far been experienced).
- h) From the procedure, do you have any stored/unused embryos? If yes, how do you plan to use them? Do you foresee any challenges?

## **Closing**

Anything else I should be aware of in developing a picture of the challenges of the new reproductive technologies?

Anyone else I should talk to?

Thank you very much for participating in this study. I appreciate your taking the time to talk to me.