TITLE

WOMEN'S EXPERIENCES OF INDUCED ABORTION IN MOMBASA CITY AND THE KILIFI DISTRICT, KENYA

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DECLARATION

I, Louisa N. Ndunyu, declare that the work presented in this doctoral thesis is my own, and that it has not been submitted in any other form to another university.

Where use has been made of any work done by other persons it has been duly acknowledged and referenced in the text.

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Louisa .N. Ndunyu
Maseno University, Kenya

DEDICATION

This thesis is dedicated to the women of Mombasa and the Kilifi districts for their courage to share and lay public their private lives with the hope that it will make a contribution towards improvement of Kenyan women's lives.

The experiences of these women left a remarkable change in me and I hope the reader will be similarly influenced by these accounts.

ABSTRACT

The primary objectives in this study were to gain a deep level of understanding of Kenyan women's experiences of seeking abortion, both safe and unsafe, and to explore how social and legal issues impact their choices and the routes they take to obtain abortion. I explored the contexts and interpreted 49 in-depth narratives of women's emic experiences of abortion in Mombasa city and the Kilifi district, Kenya, using a qualitative form of inquiry conducted between April and July 2005. Ethical Review Committees granted ethical clearance to this study. This emic work revealed gender inequity consistent with developing feminist theory and thus how women conceive gendered relationships is introduced in this analysis of women's narratives. The findings provide new insights as well as useful confirmatory knowledge, gleaned from detailed empirical evidence within Kenyan women's social contexts. The women have revealed the evidence through their narratives; such an approach is largely missing in existing abortion literature.

The prominent finding is that women do not abort motherhood, but they do abort particular pregnancies to protect motherhood; to avoid a difficult motherhood likely to compromise the quality of care they envisage for their potential and existing children. This includes ensuring the best nurturing environment, paternal and religious identity, social legitimacy. The abortion decision is difficult to make and thoroughly considered. The married women make a consultative decision with their 'breadwinners' having the upper hand.

Legal barriers cannot bar abortion but entrench inequities in abortion care access, heighten secrecy, stigma, and hamper prompt comprehensive post abortion care seeking. Thus, financial resources, peers, geographical remoteness, and knowledge significantly influence the type of abortion accessed. Consequently, unsafe abortion threatens motherhood of the most vulnerable groups of women.

The foremost recommendation is that public health law must ensure healthy, enjoyable, dignified motherhood for the women; hence safe early abortion (first trimester) must become accessible to alleviate existing health care inequities.

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LIST OF ABBREVIATIONS

Acquired immunodeficiency syndrome	AIDS
African Doctoral Dissertation Fellowship	ADDRF
American Psychological Association	APA
African Population and Health Research Center	APHRC
Adolescent Reproductive Health and Development	ARH&D
Community based distributors	CBDs
Comprehensive post abortion care	cPAC
Central Bureau of Statistics[1]	CBS
Constituency development fund	CDF
Convention on the Elimination of All forms of Discrimination against Women	CEDAW
Community Health Worker	CHW
Coalition on Violence Against Women	COVAW
Coast Provincial General Hospital	CPGH
Contraceptive prevalence rate	CPR
Centre for the Study of Adolescent	CSA
Choice for Termination of Pregnancy	CTOP
Department for International Development	DFID
District Health Management Team	DHMT
District Public Health Nurse	DPHN
District Public Health Officer	DPHO
Division for Reproductive Health	DRH
East, Central and Southern Africa Obstetricians and Gynaecological Society	ECSAOGS
Federation of Gynaecologists and Obstetricians- International	FIGO
Family Life Education	FLE
Family Planning	FP
Government of Finland	GoF

[1] The Central Bureau of Statistics (CBS) is currently known as the Kenya National Bureau of Statistics (KNBS)

Government of Kenya	GoK
Health Centre	HC
High dependency unit	HDUs
Human immunodeficiency virus	HIV
International Conference on Population and Development	ICPD
In-depth interview	IDI
International Development Research Centre	IDRC
Infant mortality rate	IMR
Institute of Primate Research	IPR
Information technology	IT
Kenyatta National Hospital	KNH
Kenya Medical Research Institute	KEMRI
Kilifi District Development Plan	KDDP
Kilifi District Hospital	KDH
Kenya Shilling	KES
Key informant interview	KII
Kenya Medical Associated	KMA
Kenya National Bureau of Statistics	KNBS
Kenya Obstetricians and Gynaecological Society	KOGS
Maternal and Child Health	MCH
Millennium Development Goals	MDGs
Mombasa District Development Plan	MDDP
Mombasa District Hospital	MDH
Ministry of Health	MOH
Ministry of Public Health and Sanitation	MOPHS
Maternal Mortality Rate	MMR
Manual vacuum aspiration	MVA
National Academy of Sciences	NAS
National AIDS/STI Control Programme	NASCOP

National Coordinating Agency for Population and Development[2]	NCAPD
National Council for Population and Development	NCPD
National Research Development Corporation	NRDC
Non-governmental organizations	NGOs
Officer Commanding Police Division	OCPD
Post abortion care	PAC
Post-exposure prophylaxis	PEP
Public Health Technicians	PHTs:
Principal Investigator	PI
Pelvic inflammatory diseases	PID
Reproductive Health	RH
Reproductive tract infections	RTIs
Traditional birth attendant	TBA
University of KwaZulu-Natal	UKZN
United Nations	UN
United Nations Development Programme	UNDP
United Nations Children's Fund	UNICEF
United Nations Fund for Population Activities	UNFPA
University of Nairobi	UoN
United States Aid for International Development	USAID
Village health nurse	VHN
World Health Organisation	WHO
World Summit on Sustainable Development	WSSD

[2] The NCAPD was formerly known as the National Council for Population and Development (NCPD)

CHAPTER ONE

1.0 GENERAL INTRODUCTION

1.1 Introduction

Kenyan women are among the less than 25 per cent of the world's women who are subject to the most restrictive laws that permit abortion only if "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger" should the pregnancy continue (Constitution of Kenya, 2010[3]; Van Look and von Hertzen, 2003), medically referred to as therapeutic abortion. Otherwise, the Penal Code Cap 63[i] prohibits willful termination of pregnancy declaring the woman or her provider guilty of a felony. The guilty parties are liable to imprisonment ranging between seven and fourteen years for the woman and three years for the provider (Laws of Kenya, 2008; Lema and Kabeberi-Macharia, 1992:35). Some medical practitioners observe that despite the legal provision for therapeutic abortion in Kenya, most health providers lack proper interpretation of the existing law and regard all terminations as illegal (Personal communication with Prof. J. Karanja[4], 2006). In contradiction, the new item stating "the life of a person begins at conception" contained in the clause on Right to Life Article 26 precludes any type of abortion (Personal Communication with Kenyan lawyer, 2011).

The term "abortion" is derived from the Latin *aboriri*, meaning "to perish" (Millar, 1934 In: David, 1992:3). In clinical descriptions, 'termination of pregnancy' or simply 'termination' is terms used to refer to abortion. The latter term is more neutral and devoid of the stigma often

[3] The newly promulgated constitution of Kenya (Republic of Kenya, 2008), passed through a referendum on August 4, 2010, maintained the status quo in restriction of abortion. In the Bill of Rights (Chapter Four), the clause on Right to Life Article 26 states: (1) "Every person has the right to life. (2) The life of a person begins at conception. (3) A person shall not be deprived of life intentionally, except to the extent authorized by the Constitution or other written law. (4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law (Republic of Kenya, 2008)."

[4] Prof. J. Karanja Obstetrician/Gynaecologist, University of Nairobi/Kenyatta National Hospital

associated with it. In the medical profession, abortion encompasses both early spontaneous[5] (involuntary) and induced (voluntary) abortion. However, the public associate the term with chosen clandestine terminations carried out in squalid conditions. Throughout this document, the terms abortion and termination of pregnancy are used interchangeably and refer to induced abortion unless otherwise specified. Abortion is the premature removal or expulsion from the uterus of a human foetus or embryo, resulting in or caused by its death, before it attains viability, that is, before it is capable of independent life. Viability is usually defined in terms of duration of the pregnancy but sometimes by weight and length of the foetus (Kenyon, 1986:19, 20). The World Health Organization recommends that a foetus is viable when the gestation period has reached 22 weeks or more, or when the foetus weighs 500g or more (Oats and Abraham, 2005). Induced abortion, particularly unsafe abortion, is the main interest of this investigation.

Induced abortion is the removal or expulsion of the conceptus from the uterus by human intervention (Llewellyn-Jones, 1974: 311) before the 22nd gestational week by artificial means. In the local Kiswahili and Kigiriama/Kichonyi languages of our study area the terms *-avya mimba* and *kumboza mimba* (remove pregnancy) respectively, are synonymous to induced abortion. Deliberate termination of pregnancy can be by means of safe or unsafe procedures. Safe abortion is a procedure for terminating an unwanted pregnancy by skilled persons using appropriate tools in a sanitary environment. For the purpose of this study, terminations reported as having taken place in health facilities registered with the then Ministry of Health[6] are categorised as safe abortions. By contrast, unsafe abortion[7] is a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both (WHO, 1992). Thus, procedures conducted by skilled persons in unsanitary conditions also fall under the category of unsafe abortions. Unskilled

[5] Also commonly known as miscarriage, spontaneous abortion is an involuntary untimely delivery of the foetus before the 22nd gestational week due to natural causes or accidental trauma. In the Kiswahili language *mimba isiyo riziki* literally translated means a 'pregnancy that is not one's luck/blessing', and is an inclusive phrase referring to therapeutic abortion or involuntary pregnancy loss such as miscarriage or stillbirth. However, note that a stillbirth is by obstetric definition distinct from a miscarriage. A stillbirth is a foetal death after 22 weeks of pregnancy and should be registered, with burial or cremation done as for adults, with a certificate issued (Potts et al., 1977:1).
[6] The Ministry of Health (MOH) was in 2008 split into two [Ministries of Public Health & Sanitation and the Medical Services] in a political arrangement following the formation of a grand coalition government that ended the post-election violence of 2007/2008. Following the presidential elections 2013 the President Uhuru Kenyatta's administration remerged the Ministries into one MOH in line with the Constitution 2010.
[7] The term unsafe abortion may also apply to a miscarriage when inappropriately managed by unskilled persons.

service providers neither appear in the registration record of the Ministry of Health nor are they on record as having received on-going post-abortion care training at the time of field study. The reverse is true of skilled persons. Unsafely induced abortions [an age-old public health and social issue that Hippocrates raised concerns about as early as 400 BC] are the main focus of this study. Today, unsafe abortion remains a major challenge and is characterised by stark differences at global, regional and country levels that are in tandem with variations in the legal statuses of abortion.

The rate at which women seek abortion is strikingly similar for women in developing and developed countries[8]. About one in five pregnancies worldwide are aborted (Sedgh et al., 2007). However, severe inequalities exist in access to safe abortion services and the consequences of unsafe abortion [id21 health focus 2007 www.id21.org]. Restrictive abortion laws contribute to the high prevalence of unsafe abortion in sub-Saharan Africa and related preventable deaths and injuries (Rasch, 2011; id21 health focus 2007 www.id21.org; Warriner, 2006; Berer, 2004; Brookman-Amissah & Moyo, 2004; Sanger, 2002; Alan Guttmacher Institute, 1999a; Rogo et al., 1999a; Ba-Thike, 1997:98; Frejka T. 1985; David, 1992). Sub-Saharan Africa carries the highest burden of unsafe abortion worldwide and very restrictive abortion laws. Notwithstanding that Africa accounts for only thirteen per cent of all women of reproductive age in developing countries. Thirty-one unsafe abortions occur for every 1000 women of reproductive age in sub-Saharan Africa, compared to only 2 unsafe abortions in Europe and a negligible number in North America (WHO, 2011). The global reduction in induced abortion estimates from 46 million to 42 million shows greater decline in developed countries than in developing regions.

All of the estimated 19.7 million abortions occurring in developing regions are unsafe and happen to women in low-income countries and groups at all these levels. Of the 5.6 million abortions reported in Africa in 2003, 5.5 million were unsafe, the bulk of these being in eastern Africa (39 per 1000 women aged 15-44 years) with Kenya carrying the highest health burden (APHRC et al., 2013; Say and Shah 2008). The Western African region follows Eastern Africa closely in the number of women that seek unsafe abortion, the least being Southern Africa

[8] Data from international health organizations and research institutions such as the World Health Organizations; the Guttmacher Institute and Population Reference Bureau

(Teklehaimanot, 2002:146). Unsafe abortion in developing countries, particularly in Africa, is of great concern because of its contribution to the high maternal morbidity and mortality. Sub-Saharan Africa is the only world region in which the number of maternal deaths increased between 1990 and 2005 due to insignificant declines in the maternal mortality ratio (Berer, 2007:6). This state is explained by the high numbers of unsafe abortions reported in 2003 than in 1995, the result of high levels of unmet need for contraception (Singh, 2007).

The abortion law in Kenya has not changed since independence despite the fact that social values regarding sex, pregnancy and fertility continue to change dramatically (Teklehaimanot, 2002:146). As discussed below, the traditional patriarchal scripts that sanction the notion of sex for procreation, and the religious ban against sexuality (Sewpaul, 1996:200) are increasingly under challenge in contemporary Kenya. The increase in age at first marriage far exceeds the increase in age at first coitus (KNBS and ICF Macro, 2010; CBS et al., 2003, Blanc and Way, 1998, Mensch et al., 2001:286). Hence, by the time they are 20 years of age, more than 80 per cent of Kenyan women have experienced sexual intercourse (Muganda-Onyando and Omondi, 2008:28). Most school-going girls engage in premarital unprotected sex without intending to bear children or marry as they prefer to stay in school. Communities are increasingly placing greater value on women's schooling because acquisition of skills is associated with improved economic prospects. Today, having a baby or marrying at an early age makes continuation at school and career development almost impossible despite supporting education policies in Kenya.

In addition, the burden of childbearing and the costs of childrearing before marriage are often shouldered solely by the concerned women, leading to a bleak economic future for them and their families. This makes the consequences of early pregnancy more severe than was the case in the past (Mensch et al., 2001). Similarly, the trend in increased desire for smaller family size by married women is demonstrated by successive demographic and health surveys (CBS et al., 2003, KNBS and ICF Macro, 2010). Sadly, these rapid changes have not been accompanied by an equivalent increase in the use of effective means of pregnancy prevention. Despite the favourable Adolescent Reproductive Health and Development (ARH&D) Policy (2003), dominant social norms and values deny these school-going girls access to reproductive health

information, services, and support, to make responsible life choices. Compound challenges in the availability and access to family planning services by population cohorts at risk of unintended pregnancy (youth and adolescents of reproductive age 15-24 years and adults of reproductive age 25-49 years) portend increased reliance on abortion.

Legal restrictions on abortion limit scientific literature on the issue in sub-Saharan Africa, particularly Kenya. Thus, most abortion studies have focused on issues of epidemiological prevalence, the characteristics of abortion seekers, the reasons for abortion, their medical sequelae and estimated costs. These studies have employed quantitative methods using medical records of women seeking care in public health facilities following complications of unsafe abortion. These statistics do not capture experiences of abortion for women and their social contexts. The data also excludes many survivors who seek treatment in private health facilities or through other means or those who do not seek treatment at all after they abort a pregnancy (Solo et al., 1999). Therefore, this public health issue has so far been presented in a statistical form with the women's voices and their contexts lacking. Yet the latter would help impress the sufferings and the need for urgency in addressing the problem. In a keynote seminar address Caldwell (1996) argued that the social context of abortions reflects a complex interaction between culture, religion and the law. He argued for the use of a nuanced anthropological tool to investigate this issue. In South Africa, unsafe abortion has persisted even after abortion was legalised in 1996 prompting Varkey (2000) to suggest that the socio-cultural background of the society affects decisions and behaviour regarding abortion.

The few qualitative studies of abortion in Kenya have focused on the general population, but again, the researchers have not reached women who have had an abortion. There are many different experiences and decision points for women who seek to terminate a pregnancy. However, current literature fails to address them and to date the issue of abortion remains marginalised. The purpose of this study was to fill this gap; the voices of women provided vivid pictures of their varied experiences of abortion (safe versus unsafe) and profound knowledge of the heavily laden socio-cultural milieu in which abortion is experienced (Nyanzi et al., 2005). In addition, the study described how the diverse backgrounds of women impinge on their abortion decisions at different stages of their reproductive cycles. This study was about explaining why

women induce abortion and about understanding how women make sense of their actions, the interpretations women use to make sense of social settings. I explored the contexts and interpreted 49 in-depth narratives of women's emic experiences of abortion in Mombasa City and the Kilifi district (rural) of Kenya, using a qualitative form of inquiry conducted between April and July 2005. In what follows in this chapter, I outline the study objectives, pose the basic questions the study aimed to answer, and present an overview of topics and emerging themes found in the thesis chapters. This emic work revealed gender inequity consistent with developing feminist theory and thus how women conceive gendered relationships is introduced in this analysis of women's narratives. The discussion starts with an elaboration on the problem statement.

1.2 Problem Statement

> "Many poor women (in Kenya) have died in back-street health centres while trying to terminate pregnancies illegally. Illegal procurement of abortion, like prostitution, has existed for a long time and only the poor suffer since they cannot afford to pay for medical services. To avoid death of these women, a law should be enacted so that those affected could go directly to public hospitals for that purpose" (Hon. Martha Karua) [9]

Abortion is prevalent in Kenya and constitutes a major public health and social issue. The national induced abortion rate is 48 per 1000 women of reproductive age and an induced abortion ratio of 30 per 100 000 unsafe abortions (APHRC et al., 2013). The Coast/North-Eastern region has induced abortion rate and ratio of 51 and 32 respectively which is higher than the national estimates (APHRC et al., 2013). Deaths due to maternal causes are deplorably high at 488 per 100, 000 women (KNBS and ICF Macro, 2010) a situation that has persisted since the nineties. The then Ministry of Public Health and Sanitation highlights maternal and child health

[9] (Daily Nation, 13, July 2003) Address at a Parents' meeting in a school by a female Minister in the Ninth Parliament (period 2002-2007).

as its major national challenge (MOPHS, 2009-2015; MOPHS, 2008-2012). In Kilifi, the Maternal Mortality[10] Ratio (MMR) was 423 per 100,000 in the year 2000 (GoK, 2001a:63).

Maternal causes constitute 27% of deaths in women aged 15-49 years. Approximately 14, 700 Kenyan women of reproductive age (15-49 years) die each year due to pregnancy-related complications (UNDP, GoK, GoF, 2005:103). One in every 30 of these deaths is due to complications of unsafe abortion (Ziraba et al., 2009; Gebreselassie et al., 2005; NCAPD, 2005; Nzau-Ombaka, 2001; Rogo et al., 1999a; Rogo et al., 1999b; Lema et al., 1996). Annually, over 20,000 women are admitted to hospital following an abortion; this translates to an estimated 800 unsafe abortions every day in Kenya leading to the deaths of 2,600 women every year (Gebreselassie et al., 2005). About 50-60% of beds in acute gynaecological wards in Kenya's major public hospitals are occupied by women with abortion-related complications (Rogo, 1996). It is estimated that amongst women attending for emergency treatment a quarter of them obtain repeat abortions and anecdotal evidence suggests that it could be as high as 4 out of 10 (Solo et al., 1995). While the figures above are alarming enough, there is no doubt that being public hospital-based they are an underestimate. For example, a cross-sectional study of rural (n = 278) and urban women (n = 473) admitted in Tanzanian hospitals with alleged miscarriage found that more than sixty per cent had unsafely induced abortion (Rasch and Kipingili, 2009).

An unknown but possibly equal number of women suffer similarly serious complications from attempted abortions, but cannot obtain treatment (Warriner & Shah, 2006; Gebreselassie et al., 2005; WHO, 1992) for various reasons. For each woman who dies, thirty more suffer disabilities, both temporary and permanent. They live daily with reproductive ill health (knowingly or unknowingly). Among these, some live with secondary infertility, while others suffer the effects of reproductive tract infections (RTIs) (Say and Shah, 2008:2). They may never attend a health facility because they have no effective access due to geographical isolation or are simply afraid of legal repercussions. Also, survivors of unsafe abortion may not take notice of signs of any outward complication. However, the absence of outward complication in the vast

[10] The International Classification of Diseases, Injuries and Causes of Death- 10th Revision defines a maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any causes related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes".

majority of induced abortions does not necessarily imply that such procedures are safe (WHO, 1992). Significant causes of death include excessive blood loss, infection, and particularly, septicemia (poisoning) (Grimes et al., 2006:1908).

Inequities in access to abortion services are stark. The women most affected by unsafe abortion are economically poor and below 24 years of age (Shah and Ahman, 2004:13; Oye-Adeniran et al., 2004; Teklehaimanot, 2002; Rogo et al., 1999a; Bankole et al., 1999; Solo et al., 1999; Ankomah et al., 1997). These women are young, in the prime of life and could be students or young mothers. The ramifications of unsafe abortion are enormous for the women, their families, the community and the country in general. When girls drop out of school due to abortion-related illness, they remain economically disempowered and their economic futures are threatened. Women are the food producers, caregivers, and sustain the next generation. When maimed, with secondary infertility, and possibly suffering from stigma and other socio-psychological consequences, their ability to work is compromised affecting household members (Grimes et al., 2006:1914). The death of these women is a great loss to their children, whose health and education are affected and who are likely to fall into deeper poverty and to become objects of exploitation (UN, 2005:22). This perpetuates the cycle of poverty from one generation to the next.

Seriously addressing the poor health and deaths of more than half of Kenya's workforce is imperative for sustainable economic development. In particular, women are the drivers of rural economy. Sadly, the chronic ill-health caused by experiences of unsafe early sexual activity, unwanted pregnancy, unsafe abortion, and HIV infection, are avoidable. If Kenya fails to meet the targets for MDG5[11], it will reflect on the value attached to women by the country. Maternal mortality ratio (MMR) is an indicator of women's social status in a country (Berer 2007:13; Grimes et al., 2006; Fathalla, 2003; Berer, 2002; Varkey, 2000).

Post-abortion care (PAC) services in health facilities address only the tip of the iceberg of the unsafe abortion problem. Even in as much as it saves lives, post-abortion care will not eliminate

[11] Millennium Development Goal 5 (MDG5): three quarter reduction in maternal deaths by 2015. The first four MDGs concerning eradication of hunger, poverty, free education and childhood mortality are dependent on the success of maternal health.

unsafe abortion (Brookman-Amissah and Moyo, 2004: 227), neither does it repair permanent injuries and scars. The tragedy is that nowadays simple, safe, and cheap techniques exist for early abortion such as the manual vacuum aspiration (MVA) to empty the uterus, and medication such as misoprostol (Okonofua, 2005; Okonofua et al., 2005; Fathalla, 2003; Rogo et al., 1999b). These technologies are woman-friendly and give more independence and privacy than ever before. In a country with a public health care system that is currently desperate for lack of resources to provide the minimum essentials (MOPHS, 2008), it is unacceptable that an annual estimate of KES[12] 18 million is spent to treat complications arising from unsafe abortions (Gebreselassie et al., 2005).

The root cause of abortion is unintended pregnancy, which is largely avoidable. Unintended pregnancy continues to be a concern to public health and a social challenge in Kenya (David, 1992). Forty-three percent of births among women 15-49 years are either unwanted (17%) or mistimed (26%) a trend that has persisted for more than one and a half decades (KNBS and ICF Macro, 2010; CBS et al., 2003). At the Coast Province, the unmet need for contraceptive is more than 24 per cent with the unmet need for spacing being highest (16.2%) in the country. Less than 2% of married women in the Kilifi district use contraceptives. Forty-seven percent of births among Kenyan adolescents[13] are either mistimed (32%) or unwanted (15%) (KNBS and ICF Macro, 2010). Generally, married women living in the rural areas and those that are in the lowest wealth quintile have high unmet need for family planning, 27% and 38% respectively (KNBS and ICF Macro, 2010). This implies a high rate of unintended pregnancy among these groups of women who constitute the majority of the total married women in the country. Unsurprisingly then, abortion contributes significantly to the observed fertility decline in Kenya (Robinson & Harbison, 2006). A 2003 national survey of secondary school students in Kenya showed 13% of students had experienced their first pregnancy by age 14 while 10% had been pregnant and had given birth or had an abortion (Muganda-Onyando and Omondi, 2008:28). Over 72% of them (10-24 years) indicated that their first pregnancy was unplanned (CSA/UNICEF, 2003).

[12] Currency exchange used in this thesis document is the Kenya Shilling (KES). 1 Kenya Shilling (KES) is equivalent to USD 70 at the time (2005)
[13] Persons age 10-19 years

Reasons for the occurrence of unintended pregnancy among more than half of these sexually active unmarried women is non-use of any modern method of contraception due to limited access to information, services and supplies (KNBS and ICF Macro, 2010; NASCOP, 2007; Rogo et al., 1999a; NCPD, 1996; WHO, 1998). In addition to denouncing abortion, cultural and religious morality in Kilifi and Mombasa, as in most communities in Kenya, disapproves of premarital sex, contraceptive use, and resulting pregnancy; simultaneously, cultural barriers hinder involvement of men in birth control. Among users of contraceptives countrywide, high discontinuation rates and incorrect use of short-term methods are prevalent as well as method failure (KNBS and ICF Macro, 2010; Hubacher, 2008). Fear of side-effects and health concerns make women averse to use of family planning methods (KNBS and ICF Macro, 2010). Besides incidences of sexual abuse, rape, or non-consensual sex, sexually experienced women are at risk of conceiving even where contraceptive use is correct and consistent because contraceptives do not guarantee 100% protection. Below is a table showing the sexually active women's risk of becoming pregnant in any one year.

Table 1-1: Pregnancy risk by method of birth control in any one year

Method of birth control	**Pregnancy risk**
No contraception	over 80%
Natural methods	2%-20%
Male condom	2% (2%-15% with less careful use)
Implant	1% over first year, 2% over 5 years
Injectable	less than 1%
Oral pill	Less than 1% (perfect use); 2%- 8% (typical use)

Source: Brien and Fairbairn 1996:3;
http://en.wikipedia.org/wiki/Combined_oral_contraceptive_pill

Further, both individually and culturally, it takes time to learn about effective birth control. Once individuals come to accept the need for fertility control, it is likely that first attempts at contraception will be relatively ineffective (Brien and Fairbairn, 1996). Regular use of contraception is not a simple matter during adolescence even in developed countries (Glasier et

al., 2006). Little knowledge, little access to services, inability to negotiate contraceptive use, and less than average decision making power regarding reproductive health compared to older women, all result in low uptake and high rates of ineffective use of contraceptives. Adolescents, regardless of marital status, often face difficulties in accessing contraception. Lack of contraceptive security also contributes to hindering effective preventive measures for all women (MOH, 2007:13). In addition, changes in circumstances such as abandonment, health problems, and financial difficulties, can make wanted pregnancy unwanted. Thus, unplanned and unwanted pregnancies are a fact.

Premarital pregnancy carries with it adverse social, economic, health and psychological consequences for the young woman (Hess, 2007; Rogo et al., 1999b:7) leading to poverty and loss of prospects for future marriage (Izugbara et al., 2009; Rogo et al., 1999b). In the absence of contraceptive use, early motherhood leads to the likelihood of high fertility, unwanted pregnancy and repeat unwanted pregnancy. Against the backdrop of chronic poverty, and with little partner support, an unwanted pregnancy triggers a chain of complex questions and circumstances for the woman to navigate. The complex and sensitive process that leads to the decision to seek abortion will help explain the underlying reasons for abortion (Bankole et al., 1998).

Legal restrictions have not prevented abortions from occurring but instead have succeeded in keeping them away from public scrutiny and oversight (Sanger, 2002). This is because the abortion laws fail to address the social reasons why women consider pregnancy termination (Rogo et al., 1999b). Hence, abortion happens clandestinely. Unfortunately, most of these abortions are unsafe and unnoticed, and maim and claim the lives of many women, hence earning the description of ‘silent pandemic’ or ‘invisible scourge’ (Grimes, 2003; Grimes et al., 2006: 1908). Providers include a variety of unskilled individuals or clinical environments that are below WHO minimum medical standards or both (WHO, 1992). Traditional communities in Kenya have used and continue to use herbal abortifacients and infanticide is adapted as a solution to unwanted pregnancy and birth (Rogo et al., 1999b:7; Lema and Njau, 1990). When asked, almost all Kenyans interviewed in various studies report that illegal abortions were common and every woman interviewed knew of someone who had had an abortion (Ankomah et al., 1997; Kekovole et al., 1997; Izugbara et al., 2008). Another woman parliamentarian who has

publicly acknowledged the urgency of addressing unsafe abortion is Hon. Charity Ngilu who, when Minister of Health, advocated for action to repeal the abortion law to prevent deaths.

> "We cannot keep sweeping the abortion debate under the carpet while thousands of women especially adolescents, keep dying in such big numbers every year" (Hon. Charity Ngilu).[14]

What is known about unsafe abortion in Kenya has so far been largely statistical therefore the problem has remained underground with little public understanding of its extent and ramifications to women, their families and their communities. Generally, matters of sexual and reproductive health are best explored using a qualitative form of inquiry because they are gendered, personal, private, rarely discussed and sometimes considered as taboo topics and/or have legal implications therefore are sensitive. Qualitative studies in Africa and Kenya specifically, have attempted to fill the information gap left by quantitative studies. However, as the review in the next chapter suggests, these studies have not interrogated individual experiences of abortion for women within their varied social contexts.

To date, little is known of these experiences, particularly with unsafe abortion in Kenya, and Africa. This is because, as earlier discussed, the majority of women do not reach public hospitals where the bulk of surveys and interviews have been conducted. Even then, the social stigma and legal implications of the procedure makes it difficult for researchers to obtain this sensitive information directly from women who seek hospital treatment for abortion-related complications. We also know little about abortion decision-making processes or about these women's perceptions of abortion. Yet it is in Africa, particularly East Africa (more so, Kenya) where women experience the highest levels of unsafe abortion and related injuries and deaths (Say and Shah, 2008:2; id21 health focus 2007 www.id21.org; Ahman and Shah, 2002; Rogo et al., 1999a).

[14] Daily Nation, 23, December 2003 Minister and Member of the Ninth Parliament (period 2002-2007) urging the government to declare abortion a national disaster!

Furthermore, the high prevalence of HIV and AIDS in the continent is bound to have an effect on the increased burden of abortion-related disabilities and deaths as the numbers of unwanted pregnancies rise. The reverse is also true that the high incidence of unintended pregnancies have implications for increased burden of sexually transmitted diseases and HIV and AIDS. HIV prevalence among pregnant women at the time of the Kenya AIDS Survey was 9.0% (NASCOP, 2007) which is higher than the national prevalence of 7.1% among adults aged 15-64 years old. Although an estimated 67 percent desired to delay pregnancy by two or more years, less than half of them were using modern contraceptives (NASCOP, 2007)

It is noteworthy that the National Reproductive Health[15] Policy (2007) document and the National Reproductive Health Strategy (2009-2015) are silent on unsafe abortion, the pandemic that contributes to a third of maternal mortality and a cause of suffering for many Kenyan women. Only the Adolescent Reproductive Health and Development (ARH&D) Policy (2003) makes brief mention of unsafe abortion, the primary reason being that the issue is believed, erroneously so, to affect unmarried adolescent women only. This makes it acceptable to dismiss unsafe abortion as rare and a moral issue, thus deepening the stigma. There is also insufficient documentation of the provision of safe, legal abortion in the public and private health sectors in Kenya where safe terminations (even if illegal) are sometimes provided at the discretion of the provider (Gebreselassie et al., 2005).

Lack of firsthand information on abortion from women has contributed to the neglect of the problem which at best is viewed solely as a moral issue rather than a public health problem. The need to understand the abortion issue from women's viewpoints has become urgent for public health. Kenya lacks an efficient and reliable reporting system that will help manage and monitor the state of safe motherhood even as the countdown to 2015 progresses. Failure to meet the MDG5 has great negative consequences on other MDGs related to child and maternal health, HIV and AIDS and other communicable diseases, and gender equality and equity. It also means

[15] Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, to control their fertility (DFID 2004:4).

no progress has been made towards the MDGs on eradicating extreme poverty and hunger (DFID, 2004: 3). Hence, this study aimed at giving human faces to the statistics by positioning women's lived abortion experiences within their social context and empowering their voices.

In summary, developing a scholarly understanding of women's experiences of abortion in Africa has important research, policy and practical implications. It will contribute to de-stigmatization of abortion and institutionalization of policies that will facilitate comprehensive reproductive health care at all levels provided for by the Community Strategy[16] (MOPHS, 2008). The purpose of the present study was to describe women's experiences with abortion, both safe and unsafe, and explain the impact of social issues on their choices and opportunities within Kenya. Specifically, I asked the following question: what are the experiences of abortion, particularly unsafe abortion, for Kenyan women? Using gender themes that inevitably emerged from the data I interpreted in-depth narratives of women's emic experiences of abortion to address this question. For example, gender inequality in power relations enforced by cultural and religious norms and values were pronounced in the narratives.

This question is key in the light of international frameworks such as: the 1994 Programme of Action of the International Conference on Population and Development, (PoA, ICPD, Cairo) (United Nations, 1999), the Beijing Platform for Action (1995), the ICPD+5 (1999), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1996), the Millennium Development Goals (MDG) and the Additional Protocols to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) (Jackson et al., 2011; Brookman-Amissah and Moyo, 2004; Teklehaimanot, 2002). These international declarations, of which many African governments including Kenya are signatory, have a common goal and commitment to improve women's health and rights by ensuring quality family planning service delivery and safe abortion services are accessible to women (primarily the poorest and the youngest who take the highest risk) to the full extent of the law, as an essential public health measure (Crane and Smith, 2006). Indeed, these documents inform the National Reproductive Health Policy and the Strategy (October 2007; 2009-2015) and the

[16] The Community Strategy is the mechanism through which households and communities strengthen their role in health and health related development by increasing their knowledge, skills and participation (MOH, 2006: 1)

Adolescent Reproductive Health and Development (ARH&D) Policy of 2003 and the Plan of Action 2005-2015 (NCAPD and MOH, 2003) which provide the framework that must enhance the sexual and reproductive health rights[17] for all Kenyans; yet fall short in implementation. The documents take cognizance of the fact women's health is imperative to development and provide benchmarks for meeting targets that would result in a decrease in the maternal morbidity and mortality. However, current demographic trends indicate Kenya lags behind in meeting the MDG5 target year 2015 (MOPHS, 2008). This is despite the 2004 declaration by the then Ministry of Health to implement the ICPD agreement.

> ''The Ministry of Health will also make efforts to ensure that women have access to safe abortion to the full extent of the law, and that health providers are aware and knowledgeable about policies and service guidelines and standards as recommended in the latest WHO guidelines "Safe Abortion: Technical & Policy Guidance For Health Systems"'[18]

1.3 Study Objectives

The primary objectives in this study were to gain a deep level of understanding of Kenyan women's experiences of seeking abortion, both safe and unsafe, and to explore how social (encompassing cultural, religious, and economic) and legal issues impact their choices and the routes they take to obtain abortion.

1.3.1 Research questions

1. What social and legal issues motivate the abortion-seeking behaviour of women in the Mombasa city and the Kilifi districts?

[17] The reproductive health rights are geared towards achieving the objectives and targets of Sessional Paper No. 1 of 2000 on National Population Policy for Sustainable Development. These are informed by the Programme of Action of the International Conference on Population and Development (ICPD) of 1994 and the Millennium Development Goals (MDGs) approved by the World Summit on Sustainable Development (WSSD) in September 2000.
[18] Director of Medical Services, Dr, James Nyikal (May 2004).

2. How do the social and legal issues impinge on abortion-related decision making among women in the Mombasa city and the Kilifi districts?

3. What are the experiences and consequences of abortion, particularly unsafe abortion among women in the Mombasa city and the Kilifi districts?

4. What policy implications do Mombasa and the Kilifi women's experiences of abortion and abortion-seeking behaviour suggest?

1.4 Theoretical Perspective

Qualitative approach is primarily interpretivist (Jackson, 2005) and informed by constructionism epistemology (Crotty, 1998). Constructionism highlights human participation in the construction of knowledge and centers on human meaning making, and the influencing contextual and cultural factors as the primary focus of inquiry. Phenomena are context-based and the process of knowledge and understanding is social and inductive (Sexton, 1997 In: Raskin, 2011). Using feminist standpoint theory (Wallace and Wolf, 2005:293), the current study explored the abortion phenomena as experienced directly by women in their everyday/everynight worlds in order to gain deep levels of understanding of the issue. Women are in subordinated positions in the Kenyan society therefore their experiences, particularly of abortion, a taboo subject to question, are denied voice. The abortion phenomenon is wrapped in silences, taboos and privacies making it necessary to hone distinctive techniques and methods[19] that unearth invisible, silenced and repressed knowledge (Tamale, 2011), and that give voice to women's experiences. This perspective facilitated in gathering data useful for answering the main question of this study: What are the experiences of induced abortion for women in Mombasa City and the Kilifi district of Kenya?

Gender issues inevitably emerged in the narratives necessitating application of the gender concept in their interpretation. Gender is the socially constructed meaning of the sexual

[19] For more details refer to Methodology Chapter Three.

differences between women and men and a tenet that not only prescribes power to women and men (Ahlberg et al., 2000), it also fashions their identities and perceptions, interactional practices and the types of social institutions created (WHO, 1998). Matters of reproduction or procreation, a dimension of sexuality, and gender play a central role in maintaining power relations in cultures and societies (Tamale, 2011; Foucault 1984 In: Ahlberg, 2000). In her book, *Politics of the Womb*, Lynn (2003) affirms this by arguing that reproductive struggles and the mutually constitutive relationship between gender, generation and governance form a central part of Kenya's pre- and post-colonial history. Procreation processes have long been important sites through which men and women of various ages and positions have constructed and contested power. Questions of who should conceive, bear, and rear children, and who should assist in childbirth have repeatedly been framed in material and moral issues (Lynn, 2003). Hence, recent studies have theorized abortion as a human social behavior (Izugbara et al., 2009, 2011; Jones et al., 2008; Mitchell et al., 2006; Williams and Shames, 2004). In their recent article, Izugbara et al. (2011) underscored the centrality of gender in the everyday (and everynight) lives of women in contemporary Kenya after interrogating lay accounts of unwanted pregnancy captured in 80 narratives of women living in Nairobi.

Society is masculine in structure (Chodorow, 1978). Public institutions, where men are positioned, form "society" and "culture" and enforce social and political control. Social norms and values guarantee men power to control marriage as an institution that both expresses men's rights in women's sexual and reproductive capacities and reinforces these rights. Men exchange women in marriage, gaining rights in women that women do not have in themselves or in men, and gaining a position in the masculine social hierarchy (Chodorow, 1978: 10). Thus, although only women experience abortion, gender power relations and the specific ways they are masked by the normalization processes which in turn mask the reality within which abortion takes place must be understood (Hinds et al., 1992: In: Ahlberg et al., 2000). To isolate the medical complications arising from unsafe abortions is to miss the complex and socially constructed meanings, the power relations and the social norms. An exploration of the study settings in CHAPTER FOUR of this document furthers the above discussion by demonstrating the gender issues embedded in the daily activities of men and women and in the institutional structures that govern their lives and how these sustain the need for abortion.

The sub-section below outlines a chronology of chapter discussions found in this document.

1.5 Overview of Chapter Contents

CHAPTER ONE provides a detailed discussion of the study problem and the study importance in creating an understanding of the abortion phenomenon through focus on experiences by women. The Chapter underscores the need for an inductive approach to fill the knowledge gap in literature. The study objectives, definitions of relevant terminologies, and the guiding gender framework are elucidated.

CHAPTER TWO reviews scientific evidence from selected studies in developed and developing countries to help the reader understand what is known and remains to be known about the abortion issue. It reveals the wide gap left by the quantitative abortion studies conducted in Kenya so far; the need for a narrative inquiry bringing to the fore the lived experiences of abortion within their context from the voices of women survivors Kenya.

CHAPTER THREE is a detailed and systematic presentation of the study design and the interpretivist methodology that informed the phenomenological research methodology. The ethical concerns built into the study design and observed in the field are elucidated. The chapter presents the challenges encountered and how they were overcome.

CHAPTER FOUR describes the characteristic profile of Mombasa city and the Kilifi district: the geographical location and infrastructure, the demographic, social, cultural, economic, and health conditions that operate to increase women's vulnerability to unintended pregnancy and the abortion outcome. This helps the reader locate women's experiences of abortion within their milieu.

CHAPTER FIVE profiles the diverse contexts within which women abort. The chapter confirms that women of diverse socioeconomic and cultural backgrounds have safe and unsafe abortion. It

explores the intricate intertwined layers of abortion motivators among women in three ideal types of relationships with men, unstable, stable, and no relationship. The women's decision to abort overrides their religious conviction and legal restrictions because it is necessary, inevitable and impelling to provide best parental care to potential and existing children. The chapter concludes that women want motherhood but abort particular pregnancies impelled by social and not legal issues.

CHAPTER SIX explores the route to induced abortion access and concluded that while legal barriers do not prevent abortion, they succeed in entrenching inequities in abortion care access, condemning the most vulnerable groups of women, who are the majority in Kenya, to unsafe abortion. Legal barriers heighten stigma and secrecy. The route to induced abortion is complex and replete with incremental delays at each stage in the process of service seeking increasing the risk for complications and implied multiple costs. The abortion decision is difficult to make and thoroughly considered even when it is a repeat abortion or a rape pregnancy. Overall, the married women make a consultative decision with their husbands while the women in unstable relationships make an independent decision to abort.

CHAPTER SEVEN discusses experiences with safe abortion. Access to safe abortion in Kenya is exclusively available for women with finances regardless of their type of relationship with men, stable, unstable or none. There exists competent medical staff in formal private health institutions of different levels located in the urban and peri-urban areas of the study willing to provide safe abortion. The simple MVA applied for most abortions give the women immediate relief. This chapter demonstrates that safe abortion poses no threat to women's health. The quality of post abortion family planning is compromised.

CHAPTER EIGHT examines the experiences and consequences of unsafe abortion. Unsafe abortion threatens the health and lives of the most vulnerable Kenyan women, the poor women, those residing in the rural areas, the young people below 20 years of age, the nulliparous and parous, students in primary and secondary education. The womenfolk are a repository of abortion knowledge. Early abortion, below 8 weeks gestation is performed in home settings by use of herbal abortifacients and has fewer complications. Providers include the *Mkunga*, the

Mganga wa kienyeji and the 'doctor'. Most women do not seek post abortion care following unsafe abortion. The chapter shows that unsafe abortion presents grave dangers to women's health and provides the reader with a useful contrast to Chapter Seven

CHAPTER NINE discusses post-abortion care. Few women access comprehensive post abortion care hence unwanted pregnancy and repeat abortions will continue to be a public health problem. The legal context of abortion negatively impacts on post abortion care seeking. The quality of post abortion care is in question. The need to create demand for post abortion care is an important recommendation. Comprehensive post abortion care cannot eliminate unsafe abortion.

CHAPTER TEN, the final chapter, is a summary of study conclusions and recommendations. The major conclusion is that women do not abort motherhood, only particular pregnancies. Safe early abortion must be available and accessible on demand for all women to alleviate existing health care inequities. Government must make motherhood easier, safer and enjoyable. Public health practitioners must make every effort to protect motherhood, hence improve women status in society.

[i] The Penal Code Cap 63 (2008) page 67

Section 158: Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.

Section 159: Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.

Section 160: Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.

CHAPTER TWO

2.0 REVIEW OF THE LITERATURE

2.1 Introduction

This chapter is a review of studies on abortion, in particular unsafe abortion, undertaken in developed and developing countries. The purpose is to highlight the known and underscore the unknown abortion experiences, particularly in Kenya. What we know about unsafe abortion in Kenya, namely prevalence of unsafe abortion and related sequelae among other facts mentioned in the first chapter, has largely come from surveys. The "Incidence and Complications of Unsafe abortion in Kenya" (APHRC et al., 2013) which I refer to here as the 'incidence study' and the "National Assessment of the Magnitude and Complications of Unsafe Abortion in Kenya" (Ipas, 2004; Gebreselassie et al., 2005) or the 'magnitude study', as it is commonly known, are the most recent and significant national studies on abortion so far. Survey design has for long dominated in providing information on the issue yet the tools are limited in explaining the prevalence and persistence of unsafe abortion in Kenya. This is because the sensitive nature of the abortion issue, due to the legal and religious restrictions, the gender issues and the stigma attached to the procedure, does not lend itself to easy capture with quantitative tools.

This review also aims to underscore that the statistical data is insufficient in giving visibility to the issue for public awareness and understanding. Furthermore, numbers, unlike real human experiences that show suffering, can easily be ignored by policy makers. Nonetheless, findings from survey methods have accumulated useful information that has provided a basis for "systematizing the determinants of abortion outcome" (Adeokun, 1991). Thus, the framework for abortion research in Nigeria developed by Adeokun (1991) has informed the kind of information gathered in CHAPTERS SEVEN AND EIGHT for a better understanding of the types of abortion experienced by diverse women and the inherent complexities in the routes to abortion.

In recent times, researchers in other parts of the globe have taken to qualitative approaches in an attempt to get a deeper understanding of the complexities of the abortion issue. These studies have delved beneath the surface to explore the social and legal contexts that impinge on the abortion experiences of women, sustaining the resort to unsafe procedures. The wealth of information existing from the findings of these studies demonstrates the need for a qualitative approach in the understanding and tackling of abortion in Africa. The studies have been conducted in countries with liberal abortion laws such as India, Thailand, Myanmar, Vietnam, Israel, Sweden, the United States of America (USA), and the United Kingdom and in countries with restricted abortion laws such as Mexico and Gabon, and have targeted women who have undergone the procedure. The study designs as well as findings of some of these studies, like the South Asia (India, Nepal, Pakistan, and Sri Lanka) studies by Ganatra and Hirve (2002), and Ganatra and Johnston (2002) have informed the present study design[20] a great deal.

In countries with restrictive abortion laws, for example Kenya, the general community has at best been the target of most quantitative enquiries of abortion. Hence, this review suggests that few studies have explored experiences of abortion from the contextual perspective of African women who have aborted, less so, Kenyan women. This study intends to fill in the gap in the existing abortion literature in Kenya and to extend the existing understanding of how women's emic experiences of abortion are linked with social and cultural issues. Reviewed in this chapter are some studies conducted in Kenya with relation to the topical issues of interest in this study, namely: the social and legal issues motivating abortion-seeking behaviour of women, and how these issues affect abortion-related decision-making; women's perception of abortion; experiences and consequences of unsafe abortion; and the implications for policy. The review focuses on what is known about abortion in Kenya and Africa due to their commonalities. This knowledge is then compared and contrasted with findings from qualitative studies done in countries mentioned above to provide "new knowledge" on unsafe abortion that is relevant to the design and to some of the conclusions arrived at in the present investigation. The discussion elucidates knowledge gaps on unsafe abortion in Kenya, some of which this study attempts to fill. What follows is a global picture of research on unsafe abortion.

[20] See next chapter

2.2 Research on Unsafe Abortion: A Global Review

The high numbers of unsafe abortions and related maternal deaths and injuries in sub-Saharan Africa makes it the region that has attracted the greatest attention from world health bodies (Berer, 2007). At the forefront is the World Health Organization which has been concerned that despite unsafe abortion being entirely preventable, it remains a significant cause of maternal morbidity and mortality in most developing countries (WHO, 2004). Hence, in more than two decades, the World Health Organization has been committed to the development of a systematic approach to estimating the regional and global incidence of unsafe abortion and associated mortality. However, data on abortion are limited due to challenges in availability of research funds and censorship of abortion topics (WHO, 2003). Additionally, the sensitive nature of abortion research makes data collection difficult (Singh, 2007; WHO, 2003). The 1987 Safe Motherhood Conference held in Nairobi drew international attention to the need to reduce maternal morbidity and mortality. It was then that researchers started to collect and make available data on the cause of maternal mortality (WHO, 2003).

In partnership with the WHO, the Guttmacher Institute has in more than twenty years provided scientific evidence on the extent and consequences of unsafe abortion in developing countries to inform policy. The Institute is a co-founder of the consortium for research on unsafe abortion in Africa funded by Britain's department for international development (DFID) and whose activities ended in the year 2012. The Consortium for Research on Unsafe Abortion in Africa was formed to address the need for increased knowledge on unwanted pregnancy and consequent unsafe abortion in order to inform policy and programme changes. The Consortium was championed by Ipas, an organization committed to improving the lives of women through a focus on reproductive health research for evidence-based policy. The African Population and Health Research Center (APHRC) based in Nairobi, Kenya is also a co-founder of the Consortium with commitment to improving sexual and reproductive health in Kenya and the African region.

The International Federation of Obstetricians and Gynaecologists (FIGO) and its affiliates, the East, Central and Southern Africa Obstetricians and Gynaecologists Society (ECSAOGS) and the Kenya Obstetricians and Gynaecological Society (KOGS) prioritise unsafe abortion under the theme of maternal morbidity and mortality in its annual conferences. Many funding organisations such as the UNFPA, DFID, IDRC, Ford Foundation, Hewlett Packard, the Bill and Melinda Gates to mention a few, have committed resources to research unwanted pregnancy, unsafe abortion, post-abortion care services, and strengthening family planning services. These collective efforts have been boosted by the recent lift on the 'Gag Rule' (imposed by President Bush's administration and lifted by President Obama's administration[21]) that curtailed the US federal funding for abortion. The impact of this was an adverse effect on the availability of contraceptive commodities in most developing countries. Kenya heavily relies on agencies funded by the USAID for its contraceptive commodities. An increase in contraceptive shortage implies an increase in the number of unwanted pregnancies and hence a rise in demand for abortion services.

2.3 Characteristics of Women at Risk of Unsafe Abortion

Global inequalities exist in the demographic characteristics of women seeking unsafe abortion. Levels of unintended pregnancy and unsafe abortion are higher among young women under 25 in Africa than in other regions of the world (Shah and Ahman 2004:15). Young unmarried women, more than married women, are more likely to choose abortion to resolve unwanted pregnancy (Nyanzi et al., 2005; Bankole et al., 1999), despite difficulties and great risk in obtaining these services. Indeed, decades of overwhelming statistical evidence confirms that in sub-Saharan Africa young women under 25 years form the bulk of admissions to public hospitals with complications of unsafe abortion, often septic (Shah and Ahman 2004:15). Indeed, up to 70% are younger than 20 (APHRC et al., 2013; Jackson et al., 2011; Dahlback et al., 2007; Gebreselassie et al., 2005; Nyanzi et al., 2005; Airede and Ekele, 2003; Otoide, 2001; Ahiedeke, 2001; Mundigo and Indriso, 1999; Mpangile et al., 1999; Okonofua et al., 1999; Ankomah et al.,

[21] Obama lifts ban on abortion. BBC News, 2009-01-24. http://news.bbc.co.uk/2/hi/americas/7847651.stm. Retrieved 2009-01-24

1997; WHO, 1993; Aggarwal et al., 1998; Aggarwal et al., 1982;). Access to a regular supply of contraceptives is not readily available to women in developing countries, less still to young unmarried women. Lack of or low use of contraceptives, particularly among adolescents results in increases in rates of unintended pregnancies leading to higher abortion rates regardless of legal status (Oye-Adeniran et al., 2004a and 2004b; Rogo et al., 1999a; Mpangile et al., 1998; David, 1992; Frejka, 1985).

Abortion studies done in Kenya[22] also show that women from varying backgrounds and of different ages, marital status, gravidity and urban/rural residences have unsafe abortions (APHRC et al., 2013; Gebreselassie et al., 2005: 1231; Biddlecom, 2008). These women are single, with no children, of low education, unemployed, students and small traders, mostly of low-income, common characteristics in most African countries (Nyanzi et al., 2005; Moodley and Akinsooto 2003: 35; Oye-Adeniran et al., 2004:81-91; Varga, 2002; Ahiadeke, 2001; Bankole et al., 1999; Lema and Kabeberi-Macharia1992:19-26; Aggarwal et al., 1982). An important variation is that even young educated urban women in Cameroon and Zambia commonly choose abortion (unsafe and illegal) despite high restrictions in the former and liberal laws in the latter country (Dahlback et al., 2007; Hollander, 2003; Johnson-Hanks, 2002). Unsafe abortion is widespread in the rural and urban areas of Tanzania (Rasch and Kipingili, 2009) and Kenya (Khasiani and Baker, 1992) as evidence by gynaecological admissions or treatment for complications in the referral hospitals. However, these studies provide a tilted picture that leaves undefined, not only the contexts of these women, but also the characteristics and contexts of those women who do not reach hospital for treatment for diverse reasons.

Although the characteristics described above are typical of most countries of the world regardless of legal conditions; and that adolescents (<20 years), regardless of marital status, are the most vulnerable when seeking reproductive health services, including abortion; qualitative studies elsewhere reveal detailed contextual characteristics of women with unsafe abortion experiences. For example, qualitative studies in India demonstrate that married adolescents were the overwhelming majority abortion seekers (Ramachandar and Pelto, 2007:63-77). Since early

[22] Refer to Biddlecom, 2008: Unsafe Abortion in Kenya, In Brief, New York: Guttmacher Institute, 2008, No. 4. www.guttmacher.org

marriage was universal most Indian adolescents who sought abortion were married (Ganatra and Hirve, 2002; Ramachandar and Pelto, 2007; Puri et al., 2005), lived in a joint family setting, and with a mother-in-law. In Vietnam, unmarried youth who lived in Ho Chi Minh City risked unsafe abortion (Nguyen and Liamputtong 2007). In Thailand, married Burmese immigrant women were vulnerable seekers of unsafe abortion (Belton, 2007: 47-62). In the U.S., while married and unmarried women of varying ages and poverty levels sought abortion (safe), majority had children and nearly half of them had two or more children (Jones et al., 2008). Conclusively, married and unmarried adolescents, nulliparous, parous, women of low socioeconomic status, economic in-migrants, undocumented immigrants, and women who lived in rural areas distant from health facilities were at greatest risk of unsafe abortion regardless of legal circumstances.

Abortion studies done in countries that permit elective abortion such as India, Thailand, Vietnam, the U.S. and Zambia discussed above have targeted women who have aborted. Unfortunately, legal sensitivities in Kenya have for long stifled abortion research ensuring the issue remained concealed and the women faceless. Far less the state and characteristics of women that seek safe abortion. The current study aimed to fill this gap.

2.4 Reasons for Abortion

The backgrounds and contexts of women at risk of unsafe abortion are compound, and intertwined with reasons women give for inducing abortion. Diverse reasons account for women's decision to abort pregnancy (Biddlecom, 2008; Bankole et al., 1998) and most are in some way related to unplanned pregnancy. For example, in the 'incidence study' more than 70 percent women seeking post abortion care were not using contraception prior to the aborted pregnancy (APHRC et al., 2013) and only 14 percent of adolescent women in the 'magnitude study' reported having ever used contraceptives before conception (Gebreselassie et al., 2005: 1234). Most young unmarried Kenyan women who were economic in-migrants from rural areas to the city have had repeat abortions because they viewed pregnancy as a barrier to socioeconomic mobility but most never used contraception (Ankomah et al., 1997) partly due to limited access (Rogo et al., 1999a: 7; Alan Guttmacher 1999b). While informative, quantitative

studies fail to capture the depth necessary in understanding the complexities inherent in the reasons for abortion and the way women (the 'experiencers') of diverse backgrounds interpret their contexts at the time. Reasons for abortion given in surveys are often superficial and fail to explain the complex systems of cultural concepts, economic factors and social structural features that sustain unsafe abortion (Ramachandar and Pelto, 2007).

Abortion studies have demonstrated the ubiquity of the practice among most Kenyan communities (Izugbara et al., 2009, 2011; Biddlecom, 2008) primarily because 'traditional' meanings of pregnancy define pregnancy wantedness. For instance, being unmarried is reason enough for most Kenyan women not to desire a pregnancy (Biddlecom, 2008; Solo et al., 1999) due to social disapproval. Abortion as a means to escape stringent punitive measures applied by various Kenyan communities, such as the Maasai (Narok district), the Luo in Nyanza region, the Meru of Eastern Kenya, exist in literature (Rogo et al., 1999b; Lynn 2004). For example, an unmarried pregnant woman faced the wrath of her family and community; she is unlikely to get a husband in the future (previously, such a woman was married off to an old man); and her schooling is discontinued (Rogo et al., al., 1999b). Punishment is more severe for unmarried than married women with unwanted pregnancies (Mensch et al., 2001; Rogo et al., 1999b).

Focus discussion groups involving stakeholders in communities of Western Kenya revealed that pre-marital pregnancy resulting from rape, incest, with an HIV infected partner, with a boyfriend who has abandoned responsibility, partner or parental insistence, lack of financial support among other poverty-related situations, and disrupting future prospects, being too young for motherhood, shame and stigmatization, make the pregnancy unwanted by unmarried women in Kenya and most African countries (Jackson et al. 2011; Izugbara et al., 2009; Dahlback et al., 2007; Nyanzi et al., 2005; Rogo et al., 1999a; Oye-Adeniran et al., 2004b). The men responsible for the pregnancies influenced unmarried women's decision to abort by refusing to take responsibility (Nyanzi et al., 2005; Rogo et al., 1999a). Often lack of money, unemployment, or being in school were reasons the conception partners abandoned women once they discovered that they were pregnant. However, older men, commonly known as "sugar daddies", provided financial assistance for an abortion or made arrangements with the service provider. Their involvement is motivated by the need to cover up their extra-marital affairs (Rogo et al., 1999a).

Among married women, pregnancy from an extra-marital affair, marital rape, where children are too closely spaced, the high cost of raising children when a woman desires to stop child-bearing, is elderly, widowed and disinherited, separated or with an uncaring or abusive husband, among other situations make the pregnancy unwanted (Rogo et al., 1999a:7). Pregnancy in a mentally ill or challenged Kenyan woman and inter-racial pregnancy were reported as unwanted regardless of marital status (Rogo et al., 1999a:7; Solo et al., 1999). Indeed, the Luo use infanticide as a solution to unwanted pregnancy and birth (Rogo et al., 1999a:7). These scholars view the modern practice by young desperate unmarried women of dumping babies in pit latrines or of suffocating infants at birth as a derivative of this ancient custom. These reasons resonate with those given by women in other African countries (Jackson et al., 2011; Hess, 2007).

Lay narratives from group discussions of Kikuyu men and women of Central Kenya revealed significant variations in their abortion-related views (Izugbara et al., 2009). The women recognized abortion as a strategy for avoiding the social risks discussed above following mistimed childbearing and impromptu entry into motherhood. The men were largely condemnatory toward abortion, viewing it as women's immoral strategy for concealing their deviation and plunge from culturally acceptable standards of motherhood and wifehood (Izugbara et al., 2009). The researchers argued that women resort to abortion challenged male's control of women's body and sexuality. These male views mirror those expressed in the emotive public debates on abortion that intermittently feature on national media, with men, particularly the bearers of religious and political leadership, as the sole voices. It is no wonder that public debates in Kenya follow a political, moral and religious perspective on abortion as opposed to a social and public health view.

A qualitative study with *bodabodamen*[23] of Uganda, where abortion is also restricted to medical reasons concluded that, though a private action, abortion was socially scripted and often collectively determined by wider social networks (Nyanzi et al., 2005: 159). The fourteen focus discussion groups, forty in-depth interviews and ten case studies revealed deeper insights in to

[23] Local name for "members of an all-male employment group of commercial motorbike riders" (Nyanzi et al., 2005: 143)

the significant roles played by *bodabodamen* as "instigators, facilitators, collaborators, transporters, advisors, informers, supporters or even punishment givers" (Nyanzi et al., 2005: 156). Evidence from narratives depicted the conflict and tension replete within the function of abortion in the diverse private spheres of the actors (women, their sexual partners, immediate family members and peers) and within the public sphere (social expectations, values, norms, accepted sexual conduct, laws- state, religious and cultural, family honor, shame, and stigma). Although the focus of this study was on the emic view of men, it manifests the power of qualitative tools in our understanding of a sensitive phenomenon.

Studies that have focused on women with abortion experiences and used interpretive methodologies reveal a wealth of insights relevant to the current study. When contraceptives are inaccessible, as in Thailand, Myanmar, rural Tamil Nadu, South India and other developing countries, married women turn to traditional methods and unqualified providers motivated primarily by the desire to limit fertility (Belton, 2007: 47-62; Ba-Thike, 1997: 94, 96, 97; Ramachandar and Pelto, 2007:63-77; Ganatra & Hirve, 2002). Among married adolescents in rural India, the most common reason for abortion is that their previous child is too young while older married women abort because they have achieved their desired family size (Ganatra and Hirve, 2002; Ramachandar and Pelto, 2007; Puri et al., 2005). While the mother-in-law and the husband make the decision for abortion for the married adolescent, older married women have 'approval' to take abortion decisions themselves (Ganatra and Hirve, 2002; Ramachandar and Pelto, 2007; Puri et al., 2005).

With the help of village health nurses (VHNs), Ramachandar and Pelto, (2007) identified and contacted women who had had abortions in the preceding six months in the VHNs' service areas. The researchers conducted in-depth interviews with 97 women from families of wide-ranging socio-economic status: ranging from a few land-owning families, to poor, landless agricultural labourers. A quarter of the women had higher secondary education of nine years or more. Findings revealed that the initial reason women give is the usual "cover explanation". The researchers used the analogy of the "layers of an onion" to describe women's motives for abortion. Further probing revealed a second layer of "text", or subtext which provided justification and elaborated on the first explanation. Additional discussions uncovered yet more

layers and "sub-texts" of explanatory details about the attitudes of other family members and social circumstances of the woman. The usual reasons for abortion cited in literature featured, with the majority either not wanting any more children or spacing the next pregnancy due to poverty. A few cited "cultural/religious reasons", "contraceptive failure" and "health reasons". However, these layers of motives and explanations for abortion were linked to cultural practices and expectations and were influenced by the modern culture of education, urbanisation and globalisation (Ramachandar and Pelto, 2007:75).

Belton (2007) explored unsafe abortion experiences of Burmese married women living in Thailand as undocumented immigrant workers. These women did not welcome pregnancy due to possible consequences such as no maternity leave, loss of jobs, cancellation of work permits, if any, fear of deportation back to Burma, and lack of family support (Belton, 2007: 48). With the help of male and female research assistants, the researcher interviewed a broad spectrum of people comprising 43 women recovering from any type of abortion, men, Thai and Burmese health workers, traditional birth attendants, and reviewed medical record of suspected abortion cases in a clinic and a general hospital. Other key informants interviewed were community leaders, women's groups and non-governmental organisations working in health and welfare. All the women were married, were either illiterate or had up to four years of school; most of them were Buddhist, very few had valid work permits, were in paid employment and contributed to the family income, and some reported domestic violence in their relationships. The complexities of women's contexts were important in understanding their abortion experiences.

In rural Maharashtra, western India, sexual abuse and coercion are common among the never married and separated adolescents. Resulting pregnancies are stigmatised as 'illegal' or "stolen goods" and therefore unwanted (Ganatra and Hirve, 2002). In Vietnam, Nguyen and Liamputtong (2007) conducted research to understand why youth engaged in unprotected sex and why they consequently had unsafe abortions. Disapproval of premarital sex and pregnancy was nearly universal in Vietnam as it is in India. Unmarried women decide to have abortions because they fear "public opinion", that is, the moral evaluation of family members, friends, and neighbours (Nguyen and Liamputtong, 2007: 92). The above reasons suggest that social conditions of childbearing influence pregnancy decisions and abortion. Indeed, years of

accumulated scientific evidence support that the decision to have an abortion is situational (Jones et al., 2008).

Recent research has set the stage for in-depth consideration of women's discussion of parenting responsibilities, to allow for greater understanding of the relationship between motherhood and abortion (Jones et al. 2008; Williams and Shames, 2004). In the expression, "I would want to give my child, like, everything in the world", this exploratory study in the United States demonstrated that women put the interests of their children above their own. All but two of the 38 women interviewed discussed current and future children and parenting responsibilities as circumstances that influenced their abortion decisions. The recruitment done by clinic staff targeted English-speaking women obtaining abortions or having an abortion follow-up visit at one of four clinics in different regions of the United States. Half of the women were living at or below poverty and almost half were non-Hispanic Black and almost half of them were in their second trimesters. The authors concluded that women who have abortions are not likely to be different from those who give birth, because often, women abort out of the motivation to be a good parent (Jones et al., 2008; Williams and Shames, 2004). The findings of the current study lend credence to this empirical evidence as discussed in CHAPTER SIX.

2.5 Abortion-seeking Behaviours

Abortion is perhaps the oldest, most common and universal method by which women have controlled their fertility, long before the law regulated the practice (Potts et al., 1977:2). A study of 350 ancient and pre-industrial societies concluded that, "It is impossible even to construct an imaginary social system in which no woman would ever feel at least impelled to abort" (Devereux, 1955 in: Petchesky, 1990: 1). Women across cultures have always known a variety of ways to manage unwanted pregnancies (Liamputtong, 2007:6; Rogo et al., 1999b:1-24; Oye-Adeniran et al., 2005:133-141) long before modern contraceptives came in to being. The difference lays in whether the social system permits safety of the procedure. Scientific evidence shows that early abortion is an ancient means of "traditional" reproductive control practice among women of many ethnic groups in Kenya. A variety of abortion methods documented in

Kenya range from herbal remedies- including teas; to chemicals- drugs mainly tablets, injections, and quinine; to physical -catheters, forceps, knitting needles and tying the abdomen. The type of method used varies with the providers. Other than the woman herself, providers include herbalists, pharmacists, nurses and support hospital staff (Biddlecom, 2008). However, there is a dearth of scientific literature on abortion-seeking practices and contexts of Kenyan women, that is, the routes to abortion. For example, what is women's knowledge base of these methods, how do they obtain these methods, how are they administered, how do they access providers, whether formal or informal? Indeed, little is known about safe abortion in Kenya, a gap that the present study attempts to fill.

Herbs and roots were commonly used abortifacients by other African women including Tanzanian, Gabonese, Malawian, and Zambian women (Rasch and Kipingili, 2009; Hess, 2007; Jackson et al., 2011; Dahlback et al., 2007). In-depth interviews with five Gabonese women aged between 16-28 years with a live-in-partner or married revealed that apart from one woman who visited a clinic where dilatation and evacuation was done, the rest self-induced using modern and indigenous methods. The methods comprised the stem of manioc (cassava) plants - known to contain cyanide- inserted in the vagina and left in place for a day, rectal enema with abortifacient leaves, vaginal ovules of medication called Cytotec (Misoprostol), injections of unknown medications purchased at a pharmacy. These women sought no medical treatment after these procedures. Three of the five women made a self-decision then sought advice from others on how to abort (Hess, 2007).

Malawian women use similar and even broader range of oral and vaginal methods as well as male methods, for example, concoction smeared on penis prior to sex (Jackson et al., 2011). Dahlback et al., (2007: 666) reported that Zambian adolescents too relied mostly on traditional medicines (local herbs and roots), oral and vaginal, to abort aided by unskilled "old women" and traditional healers. Vaginal insertion of cassava root or stem is a common practice across Zambia, Malawi and Gabon. Modern medicines such as Chloroquine, Panadol, Cafernol, oral contraceptives, sometimes blended with traditional herbs were self-prescribed by Zambian adolescents. Private physicians or clinical officers applied injections, curettage, vaginal tablets, and oral contraceptives. Most induced abortions were within the first trimester. Dahlback et al.,

(2007: 656) used semi-structured questionnaires to interview girls admitted at the University Teaching Hospital in Lusaka with a diagnosis of incomplete abortion. Selection of study participants was done after uterine evacuation and thirty-four girls self-reported induced abortion. Safe abortion is legally permitted in Zambia but the bureaucratic process of obtaining services acts as a bottleneck to access. While informative, these qualitative studies fail to provide sufficient details necessary to understand the intricate process of abortion-seeking behaviour and decision-making.

The 'magnitude study' observed that most of the women admitted for the treatment of complications from incomplete abortion, either spontaneous or induced, in public hospitals annually were in the second trimester of pregnancy, implying increased risk of morbidity and mortality (Gebreselassie et al., 2005; Brookman-Amissah and Moyo, 2004:228). The present investigation sought to provide answers to the important knowledge gap: why women delay seeking help for abortions until the second trimester. The present study also aimed to increase our understanding of the diverse routes followed by different women in an attempt to obtain abortion and post abortion care, and the challenges they endured. Abortion literature from other countries most of which permit abortion and where qualitative designs have been used provided useful insights that the present study drew from.

The stigma of unwanted pregnancy has negative implications for health seeking behaviour of young unmarried women even where abortion services have been legal for decades such as in India and Vietnam (Nguyen and Liamputtong, 2007: 79-96; Ramachandar and Pelto, 2007:63-77). In Thailand, bordering Burma, despite the availability of legal and safe abortion services, inaccessibility due to distance to clinics and legal restrictions (undocumented immigrants) encourage resort to traditional methods of abortion (Belton, 2007: 47-62). Village health nurses (VHNs) assist older married women to obtain safe abortions in government and private facilities (Ramachandar and Pelto, 2007), but do not extend the same service to married adolescents. Similarly, married adolescents are unlikely to receive post-abortion contraceptive counseling or to adopt contraception. These disparities may be partly due to societal value placed on large family size. Among the Hmong, for example, herbal medicine to induce abortion is 'allowed' for use by aging women who have had many children. However, abortion restrictions are in place

for younger women (Belton, 2007: 52; Ganatra and Hirve, 2002:76; Puri et al., 2005). Young married, never married and separated adolescents continue to rely on the private sector for abortion, often unsafe, because of the need to maintain secrecy and social 'honor' (Ganatra and Hirve, 2002). Other constraints that lead to reliance on untrained providers are limited mobility, autonomy, and control over resources within the household (Ganatra and Hirve, 2002: 83).

2.6 Consequences of Abortion

Population-based and hospital-based surveys in urban and rural areas of African countries have provided bedrock evidence of complications related to unsafe abortion (APHRC et al., 2013; Gebreselassie et al., 2005; Okonofua et al., 2005; Rasch and Lyaruu, 2005; Gallo et al., 2004 Oye-Adeniran et al., 2004; Rasch et al., 2000b; Rogo et al. 1999b; Mundigo & Indriso, 1999; Population Council, 1996). Published epidemiological research on abortion has relied on medical records in public hospitals to create awareness of abortion as a public health concern in Kenya (Ipas 2004; Rogo et al., 1999a; Ankomah et al. 1997; Baker and Khasiani, 1992; Aggarwal and Mati, 1982). In particular, Kenyatta National Hospital, which was the only national referral hospital for many years and based in Kenya's capital city, Nairobi, has been the site of focus for most abortion studies. The findings of these studies, that unsafe abortion was responsible for almost a third of obstetric morbidity and mortality, have remained relevant to the present time as little progress has been made to reduce unsafe abortion. The findings of the most recent national abortion surveys by APHRC et al., (2013) and Ipas (2004) differed little from those conducted in the 1990s and 1980s confirming that the general picture across public health facilities in the country remained unchanged.

The high abortion-related morbidity and mortality in Kenya needs attention (APHRC et al., 2013; Ipas, 2004). The most recent national 'incidence study' estimated a case fatality rate of 266 women deaths per 100 000 unsafe abortions (APHRC et al., 2013). Data were collected from structured interviews from a sample of 350 health facilities that comprised public health facilities ranging from Levels II to VI and all private clinics belonging to the Family Health Options of Kenya (FHOK) and the Marie Stopes International (MSI) in 2012. Using the Abortions

Incidence Complications Methodology (AICM) and the Prospective Morbidity Methodology (PMM), the survey revealed that out of the 157,762 women receiving post abortion care, 119,912 of them had induced unsafe abortion. Severe complications of unsafe abortion were most common among adolescents (48 percent) and those that reported to have induced abortion (58 percent).

Similarly, findings from the 'magnitude study' (n = 809) case records of incomplete abortion or other abortion-related complications from a representative sample of public health hospitals across the country showed that unsafe abortion is the major cause of the high rate of abortion-related morbidity and mortality in Kenya. Eighty per cent of the women admitted in public hospitals for the treatment of complications had incomplete abortions (Gebreselassie et al., 2005; Brookman-Amissah and Moyo, 2004:228). Twenty-eight per cent of the women had complications classified as of a high severity. Women with second trimester abortion complications were more likely to have signs of mechanical or physical injuries compared to women with first trimester complications (Gebreselassie et al., 2005: 1233). Adolescents were also more likely to have mechanical injuries than adult women were (Gebreselassie et al., 2005: 1232). The present investigation provided explanation as to why Kenyan adolescent women were more likely to be diagnosed with mechanical injuries, a high risk factor of morbidity and mortality. The explanatory findings of the present study concur with the observations made in Tanzania that the occurrence of complications varied by the method used to induce the abortion (Rasch and Kipingili 2009). The catheter or roots methods were more often associated with complications while herbs were the least associated with the same. However, the side-effects of these herbs remain unknown. Thus more research is needed to document the effects and possible side-effects of these herbs in order to better understand the consequences of unsafe induced abortion (Rasch and Kipingili, 2009: 1132).

Scientific abortion literature in Kenya and most African countries lacks emic views of physical injuries suffered, if any, and how women live their post abortion lives. Few women who undergo unsafe abortion seek treatment at the health facilities which presents major limitations for hospital-based studies (Gebreselassie et al., 2005: 1233). However, heavy reliance on health facility case records to provide information on abortion is an understandable limitation given the

overly sensitive nature of the subject in Kenya. The present study took a departure from the biomedical trend to talk directly to women with abortion experiences, in and outside hospitals, in order to obtain 'insiders' view of the consequences of the procedures, relayed in their own voices. Little is known about the psychosocial effects of abortion on women in Kenya, yet these have implications for post abortion counseling. Lessons can be drawn from empirical evidence in other African, Asian, European countries and the Americas.

Narratives from in-depth interviews with five post abortive southern Gabonese women revealed regret, guilt, and expressions of spiritual consequences as the effects of abortion (Hess, 2007). However, the author rightly noted the limitations of the study constituted factors that may have compelled these women to describe emotional and spiritual consequences: that the study setting was a church-operated hospital, she, the researcher, was a former missionary in the same hospital, the five women may have had a stronger religious affiliation than other women in other parts of the country (Hess, 2007: 47). The author suggested the need for a study with post abortive women outside a religious setting. The psychological themes of guilt, isolation and anger emerged from the phenomenological analysis of the abortion experiences of four white Afrikaans women from upper to middle class backgrounds aged 38 to 45 years in South Africa (Walters, 2009). Utilizing the theories of motherhood, gender, and reproduction to explore the various contexts, Walters underscored the complexity of abortion, with observations that women experienced these feelings differently and contextualised them differently. Therefore, individual women's experiences of abortion are uniquely important, relayed in their own voices. Empirical evidence suggests that abortion is neither all positive nor all negative, and for many women the reaction to abortion may be one of ambivalence, that is, as simultaneously being positive and negative (Walters, 2009).

In identifying her study theme, "the past reaches into the present," Trybulski (2005) concluded that thoughts, emotions, and insights about the meaning of abortion experiences permeated women's lives as life events unfolded. Triggers for recurring thoughts about past abortions were difficulties with subsequent pregnancies, life milestones, and mundane occurrences involving friends' children. These recurrent thoughts had characteristics of avoidance or suppression and intrusion. The study was a phenomenological analysis of European-American women's

responses to abortion over an extended time and the meaning of these responses. Narratives were from a convenience sample of sixteen women (well-educated and middle class; ages ranged between 38-55 years and 92 years) of diverse religious backgrounds who had aborted at least fifteen years prior to the interview for non-genetic reasons. Two women had illegal abortions and five had multiple abortions (Trybulski, 2005).

Herrera and Zivy (2002: 95-102) wanted to ascertain whether the negative effects that abortion is said to have, are universal or related to the social circumstances, and legal context in which abortion is experienced in Mexico. In Mexico, as in Kenya, the law restricts abortion and motherhood defines women's identity and worth. This has led to stigmatisation of women who have had abortion regardless of their specific situations and needs (Herrera and Zivy, 2002: 96). The researchers conducted a qualitative study of Mexican women who had undergone an abortion. They analysed the dominant meanings of femininity, pregnancy, motherhood and abortion. Civil society organisations working for women's rights put them in contact with 12 women of different ages, race, class, education and marital status. The researchers concluded that it was not the abortion decision, or the procedure, that distressed women. Instead, the context of moral disapproval, illegality and inaccessibility of abortion services and the silence that surrounded unwanted pregnancy disturbed them the most (Herrera and Zivy, 2002: 96). The researchers recommended promotion of sexual and health education for Mexican women to develop personal skills to make optimal health choices like did Nguyen and Liamputtong (2007) for Vietnam discussed below. They also recommended decriminalisation of abortion in Mexico to reduce the negative impact caused by illegal surreptitious abortions. Nevertheless, as demonstrated in the cases of Israel, the United Kingdom, Sweden, Vietnam and India below, legalising abortion alone does not reduce the negative impact abortion has on women.

Even in countries with legal abortion, a combination of the social milieu and life circumstances of women have a major role to play in abortion aftermath. A study by Remennick and Segal (2001), exploring the experiences and emotional aftermath of induced abortion comparing native Israeli Jews and Russian immigrants in Israel, aptly illustrates this point. Abortion is legal and easily available in Russia but services are of poor quality (under equipped and overcrowded clinics with impolite medical staff). Safe and efficient family planning alternatives were hardly

provided although few Russian women were willing to take up contraceptives due to fear of side effects and complications, a view shared by doctors too. In Russian culture, women perceived abortion as inevitable and relied on the procedure for 'normal birth control' (Remennick and Segal, 2001: 51).

On the other hand, abortion attitudes and experiences among Israeli Jews are shaped by a different culture in which abortion is considered the least acceptable means of birth control. The abortion law in Israel was enacted in the late 1970's and responsible sexual conduct is promoted through contraception and sex education at school, in the youth media and by NGOs (Remennick & Segal, 2001: 52). Twenty-three Israeli women and 25 Russian immigrants aged 20-39 and 24-39 respectively participated in the study. Recruitment of women who had had recent abortions was through voluntary counseling services run by the Israeli Family Planning Association which helps women to apply for abortion and also offer post abortion counseling. Recruitment of women also took place in abortion clinics (for Israeli women) and via a special counseling centre for recent immigrants in the greater Tel Aviv area. Women who had trouble making the decision to abort, had had an abortion in the second trimester, were very religious, had low self-esteem and self-efficacy, were vulnerable to post-abortion distress (Remennick and Segal, 2001: 50).

Russian immigrants reported more emotional disturbances after abortion than local Israeli women. This is because Israeli women, even those less wealthy and educated, were part of mainstream society, relatively settled, materially secure, and had family support. In contrast, Russian women were limited in all of these areas, as is often the case with immigrants, and in addition experienced marital distress, multiple role strain, and cultural maladjustment (Remennick and Segal, 2001: 63). The desire to forget the matter as soon as possible meant few women returned for post abortion counseling. The perceived moral judgment made by service providers and social workers led to women's experience of abortion services as being unpleasant. This increased the chances of negative post abortion reactions. Many Israelis viewed abortion as 'responsible sexual behaviour' and felt a sense of 'personal failure in controlling fertility'; it hurt their dignity and self-esteem. On the other hand, Russian women tended to see abortion as a misfortune and themselves as victims rather than actors, hence a theme of 'mistake', and getting involved with the wrong man. Repeat abortions were also common among

Russian women. After abortion, they were concerned about their health and future fertility, reflecting a view of abortion as a health hazard common in Russia. The authors argued that the Israeli and Russian women expressed the perceptions and beliefs that resonated with their respective cultures in relation to abortion (Remennick and Segal, 2001: 61).

When there is reduction of judgmental attitudes towards women seeking abortion services, the experiences of abortion become significantly less distressing, concluded Harden and Ogden (1999). In the United Kingdom, abortions were made legal by the Abortion Act passed in 1967, and services are obtained through the National Health Service, through private-for-profit services, or through specialist non-profit services set up by charitable organizations. However, moral stigma in service provision and access prevailed for a few decades. In their study, Harden and Ogden (1999) aimed at assessing whether the moral context which had been reported previously, persisted, by examining unmarried women's experiences of having unwanted pregnancies, and of arranging and having an abortion. The participants were 54 young women aged between 16 and 24. Recruitment and interviews (immediately after the procedure) took place in clinics and hospitals providing abortion services in the local health authority. The researchers found that although some health professionals still react to abortion judgmentally, those who actually manage the services are supportive and uncritical (Harden and Ogden, 1999: 442).

2.7 Comprehensive Post Abortion Care

Comprehensive post abortion care services (cPAC) comprises three components, that is, treatment of complications discussed above, contraceptive counseling and linkages to other reproductive care. The cPAC is an important intervention for reducing unwanted pregnancy and repeat unsafe abortions in Kenya (Solo et al., 1999). High quality contraceptive service counseling increases uptake of contraception by women who have had unsafe abortion (Rasch et al., 2004). However, the rollout of post abortion care in health facilities, which started in the late 1990s, has been very slow particularly at primary health care levels and in rural facilities (NCAPD et al., 2005). Where cPAC services are available, surveys have repeatedly cited

technical incompetence in simple modern techniques of manual evacuation among providers and poor quality post abortion care services leading to low utilisation (Gebreselassie et al., 2005; Gallo et al., 2004; Oye-Adeniran et al., 2004a). A similar situation was found in Malawi using the *WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes* (Jackson et al., 2011). Lessons from Vietnam and India where legal abortion services exist, demonstrate that unmarried, married and separated adolescent women silently suffer emotional pain and health consequences of unsafe abortion for the sake of secrecy to shield them from public opinion and maintain 'social honor' (Nguyen and Liamputtong, 2007: 79-96; Ramachandar and Pelto, 2007; Ganatra and Hirve, 2002).

The preventive role of PAC services in reducing repeat unwanted pregnancy and unsafe abortion is proven even in countries like Sweden where legal abortion has been available since 1975. In Northern Sweden, women under twenty and less educated who attended post abortion counseling one month after abortion, felt more mature and experienced after the abortion process. The study concluded that it was important for nurses and midwives to be aware of women's complex experiences with abortions in order to provide support (Alex and Hammarstrom, 2004).

The present study explored women's lived experiences of post abortion care. The inquiry focused on how, if at all, women sought treatment after unsafe abortion, contraceptive counseling regardless of type of abortion, type of information and/or contraceptive methods received and their perceptions of the service. These emic views helped gain insight into the current delivery of post abortion care that is absent in Kenyan literature. How women perceived abortion has implications for safety, treatment seeking when complications occurred and use of pregnancy prevention measures and was therefore of interest to this investigation.

2.8 Perceptions of Abortion and of the Abortion Law

The restrictive abortion laws that still exist in Kenya as in many other of the sub-Saharan African countries included, are vestiges of a colonial history that saw countries of the Western

hemisphere transport their then restrictive abortion laws and attitudes to the colonies (Cook and Dickens, 2002). These Western countries (or developed countries), and some developing countries such as China and India, liberalized their abortion laws within the period starting as early as in the 1930s, 1950s and up to the 1960s and 1970s. Currently, more than 63% of the world's people live in countries where abortion is available on request or where social factors count when evaluating a woman's request for abortion (Van Look and von Hertzen, 2003). Several African countries[24] have abortion laws that allow safe abortion services in varying degrees (Berer, 2004; Brookman-Amissah and Moyo, 2004; Oye-Adeniran, 2004) although universal access to services remains a challenge. Still, advocacy efforts are gaining momentum in several more[25] (Berer, 2004:7; Brookman-Amissah and Moyo, 2004, Oye-Adeniran, et al., 2004).

Population-based and hospital-based surveys have demonstrated that unsafe abortion is frequent in African countries with restricted abortion laws and persists in countries with liberal laws (Jackson et al., 2011; Dahlback et al., 2007; Moodley and Akinsooto, 2003: 38; Benson and Vekemans 2007:2; Harrison et al., 2000; Cooper et al., 2004; Say and Shah 2008:2). Although legal restrictions on abortion do not affect its incidence it influences safety. Hence, a legal environment can lead to low morbidity and mortality from unsafe abortion. However, legalising abortion by itself may have no impact on reduced unsafe abortion cases. Classic scenarios are Zambia and India where legal abortion has prevailed for decades but safe abortion is inaccessible to most women who need it. In Zambia, bureaucratic systems, contained in *The Termination of Pregnancy Act* of 1972, impede access to safe abortion services and their wide availability (Dahlback et al., 2007) while in India social stigma is the reason many young women seek service from private clinics, often unsafe (Ganatra and Hirve, 2002). Both circumstances sustain high morbidity and mortality rates from unsafe abortion (Grimes et.al., 2006:1913; Berer, 2004; Ganatra and Hirve, 2002). Conversely, legal restrictions on abortion do not imply entire lack of safe abortion services, as is the case of Kenya where clandestine safe abortion is variably available. Hence the conclusion that abortion should be liberalised because restrictive laws can

[24] Burkina Faso, Ethiopia, Mali, Benin, Burundi, Ghana, Guinea, Guyana, Chad, Seychelles, South Africa Tunisia, Zambia,
[25] Kenya, Nigeria, Uganda and Mozambique

neither be enforced nor are they a deterrent (Mpangile et al., 1998 and 1999). Instead, they serve to deny poor women safe abortion services because these are offered privately and are expensive.

Information on abortion perception in Kenya exists mainly in public debates that intermittently arise in the media and show that most Kenyans prefer status quo in the abortion law. Indeed, a public debate on abortion was lively in the media at the time of the field work of the present study. The intense arguments on the abortion question was partly triggered by the then on-going constitutional review process in the country and partly because of the revelation of fifteen fetuses that were found dumped on a riverbank in Nairobi City. The political, moral and religious arguments in these debates contain little careful or constructive thought or analysis and in the process the public is often 'fed' with misinformation as Potts et al., (1977:4) puts it. It is at such times of heated public debate that the Kenyan police force exercises their mandate to apprehend alleged abortionists. It was during one of these times that one Dr. John Nyamu, proprietor of a city clinic and a notable obstetrician/gynaecologist, and two nurses were arrested (Brookman-Amissah and Moyo, 2004: 227; Daily Nation, 2005[26]). They faced charges of disposing 15 fetuses wrapped in a polythene bag on a riverbank. This was taken as an indication that they were abortionists. The case continued for two years after which they were acquitted for lack of evidence.

Publicly available national-level information on attitudes about abortion and the conditions under which the procedure should be legal is lacking (Biddlecom, 2008). Few scientific studies have analysed how Kenyan women, particularly those who have had abortion, perceive the issue. Rogo et al (1999a) noted that the cultural practice of abortion and infanticide is perceived as separate from the modern law by some communities in Western Kenya. While they support the status quo in the abortion law, they do not suggest change in the cultural practices. Similarly, a poll conducted by the Nairobi-based Steadman Research Services showed that 81 percent of Kenyans did not want the law in favour of abortion reviewed (IPS, 2004). This is consistent with a study done by Kekovole et al., (1997) and the Population Council (1996) that revealed Kenyans, and especially women, were generally opposed to abortion on demand. Opinion leaders' perceptions or misperceptions are likely to heighten stigma, influence access to safe

[26]See end of this chapter- article of the newspaper magazine, Daily Nation, Wednesday, June 15, 2005.

abortion and post abortion care, and impede abortion law reforms for broader conditions. The current study explored women's emic perceptions on these issues, albeit at a non-generalizable level. Certainly, the views of women who speak with reference to their own abortion experiences are likely to differ from the views of the general public. Similarly, the views of women drawn from health facilities, as in the Western Kenyan study by Rogo et al. (1999a), are likely to differ from those of women who seek none of these services before or after abortion.

Qualitative studies reveal that medical definitions may differ from the meanings women attach to abortion. In the Thailand study (Belton, 2007), there was no common understanding of what an abortion was among Burmese married women and health workers. This led Belton (2007:50) to conclude that "abortion is ambiguous in sites of low technology" as there was no way of determining pregnancy. The perception of abortion among women differed from medical and legal views. To these women the meaning of 'blocked menstruation', which they 'unblock' using herbal medicines was not the same as abortion and had less stigma. They believed, in accordance to their Buddhist and Muslim teachings, that 'menstrual regulation', rather than 'abortion' and abortion in early gestation when it was 'only a blood clot', had 'less spiritual risk' (Belton, 2007:52). The researchers concluded that if local understanding of abortion were factored into medical and legal practices, they would improve communication of clinician-patient and quality post abortion care.

2.9 Policy Implications

The strategic assessment of unsafe abortion in Malawi (Jackson et al., 2011) aptly encapsulates longstanding recommendations made by other researchers in the field of abortion in Africa (Dahlback et al., 2010; Dahlback et al., 2007; Hess, 2007; Nyanzi et al., 2005; Rogo et al., 1999). These recommendations include: review and reform of restrictive abortion law, strengthen the national family planning programme, address the sexual and reproductive health needs of young people, strengthen post-abortion care services (Jackson et al., 2011). In addition, interventions should create stronger social support mechanisms and policies and laws should incorporate local

knowledge and practice in order to be relevant to local realities (Belton, 2007; Nyanzi et al., 2005; Rogo et al., 1999).

The Kenya Medical Association (KMA) through its Reproductive Health Committee, the Federation of Women Lawyers (Fida), the Coalition on Violence Against Women (COVAW), and the Kenya Obstetricians and Gynaecologists Society (KOGS) continue their call for repeal of the law to allow for increased reproductive health rights. Their efforts have achieved some significant success as shown by the passing by parliament of what is now the Sexual and Reproductive Health and Rights Act 2008 despite vehement opposition from Christian and Muslim religious leaders.[27] Women legislators cited in the previous chapter have been supportive of a balanced view and one "… challenged religious and other leaders to discuss abortion with open minds devoid of emotionalism and sentimentality".[28] However, the hostile political and religious environment makes these legislators unwilling to champion change publicly. Kenya could learn useful lessons from the South African case.

The process leading to the liberalisation of the abortion law in South Africa and to the Choice on Termination of Pregnancy Act (CTOP Act) of 1996 is instructive that empirical evidence, rather than public debate, must prevail in policy change. The advent of democracy in South Africa in 1994 created a unique opportunity for passing reproductive health policies and supporting laws that are among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights (Cooper et al., 2004).

The 1996 CTOP Act allows for termination on request for pregnancies of 12 weeks or less gestation provided by a certified midwife or doctor in designated health facilities. During the apartheid era, the health policy was extremely discriminatory and racially segregated. Black women received limited reproductive health services from public health facilities and relied on illegal abortions while white women relied on well-equipped private health facilities heavily funded by government resources and received legal abortion services. As a result 34% incomplete abortions from unsafe abortion were admitted in public health facilities. Based on

[27] Daily Nation, 09, December 2008
[28] Daily Nation, 23, December 2003

sound research evidence, the Act was formulated to address the public health concerns through locally appropriate reproductive health policies that were in line with the international emphasis on human rights and gender equity as spelt out in the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women (FWCW) in Beijing. This agenda was pushed by civil society organizations led by the Reproductive Rights Alliance which has to date continued to monitor implementation of the legislation and the delivery of services. South Africa experienced a 91% morbidity reduction within the period 1994 to 2001 as a result of the CTOP Act of 1996 (Benson and Vekemans, 2007:2; Harrison et al., 2007).

There has been great pressure from religious groups on government to reverse this law but in vain. The challenges experienced in South Africa have demonstrated that legislation of abortion is simply one important step towards a long journey that requires continued demonstration of commitment and capacity for implementation such as a strong public health system to ensure access to and affordability of services become a reality (Grimes et al., 2006:1913; Berer, 2004; Moodley and Akinsooto, 2003). Nonetheless, the returns are evident with the decline in maternal mortality, substantial decrease in abortion-related maternal morbidity and an overwhelming majority which had no signs of infection on admission (Cooper et al., 2004).

The voices of Kenyan women's experiences of abortion are critical to turning the tide of the acrimonious and emotional debates that intermittently feature in the media with little regard for the many women who silently endure the repercussions of unsafe abortion. There is hope that the passing of the progressive Constitution of Kenya 2010 provides basis for broad interpretation. The next chapter details the qualitative methodology applied in this investigation.

FIGURE 2-1: NYAMU AND TWO NURSES FREED

Wednesday, June 15, 2005 Daily NATION ABC MEMBEI AUDIT B OF CIRC

Nyamu and two nurses freed

But doctor in foetuses saga promptly arrested and charged afresh

By JILLO KADIDA

A Nairobi doctor and two nurses charged with murdering two foetuses yesterday walked to freedom after spending a year behind bars.

But their freedom was short-lived as they were immediately re-arrested and charged with 13 counts of killing foetuses.

No evidence

High Court judge Kalpana Rawal acquitted Dr John Nyamu, Ms Marion Kibathi and Ms Mercy Mathai, saying there was no evidence to link them to the murders alleged to have been committed between May 23 and 25 last year.

They had denied murdering an unidentified female No.1912, weighing 3.012 kilogrammes and an unidentified male No.1913, weighing 2.232 kilogrammes.

Anxious friends and relatives jammed the courtroom as the ruling was delivered. They restrained their joy until after Justice Rawal had left the courtroom. And as they left the courtroom, they hugged the newly freed trio.

Cut short

But once outside, their celebration was cut short as the three were once again arrested by policemen who were camped outside.

The three found themselves in yet another courtroom where they faced fresh charges, this time, of killing 13 babies. Under the new charge, the three were released on a Sh300,000 cash bail or Sh500,000 bond and a similar surety.

The whole thing took about half an hour from the time they were discharged of murder charges, to the time they appeared before chief magistrate's Aggrey Muchelule.

The prosecution had called 13 witnesses, but the three were yet to call any.

The three argued that the State had failed to prove the murder charges against them and demanded that they be set free. Justice Rawal said in view of the testimony that had been adduced, the court only had to ascertain whether the evidence was capable of supporting the murder charge or not.

Photo/Pa

Dr John Nyamu Muchai, Ms Marion Wambui Kibathi (centre) and Ms Mercy Kaimuri Mathai at the Nairo Court yesterday. The three were acquitted of murder charges, but re-arrested shortly afterwards and c afresh with 13 counts of killing foetuses.

In their argument seeking to have the murder charges withdrawn, Dr Nyamu and the two nurses said the murder charge was unsustainable because the foetuses they were alleged to have murdered were stillborn. "For murder to have occurred, the foetuses should have been breathing," they argued.

Discharging the murder charge against the three, Justice Rawal said the foetuses were not persons to be murdered and therefore, the three should not have been charged with the crime.

"There is no other evidence before the court for it to accept or hold otherwise. In the circumstances, I accept the opinion of Dr Njue," said the judge.

The prosecution, she said, had also failed to adduce evidence to contradict that given by a Dr Moses Njue, who said that the foetuses were stillborn. Dr Njue was one of three pathologists who examined the foetuses.

The judge said she could not disregard the doctor's evidence as urged by the State.

She was critical of the prosecution for leaving a wide gap in its case and cited as an example, the failure to summon the two other doctors to testify. She said no evidence had been adduced to link the three to the deaths of the foetuses and ordered their release.

Judge ruled

The judge ruled: "I do not find any evidence against the three and I direct that they be released, unless otherwise lawfully held."

Asking the court to convict the three, the prosecution had claimed it had proven its case against them. It claimed the foetuses had been strangled to death.

And less than 20 minutes later, the three were once again before magistrate, where they denied counts.

They are accused of comm offences on diverse dates betw 23 and 25, last year, in Nairol with others not before the cour

Each of them faces 13 counts four female, four male and f foetuses whose sex could determined.

After the court clerk finishe the new charges to the accu lawyers Cliff Ombeta, T Kajv Lucas Naikuni applied for bail.

Mr Ombeta said his client ha custody for long, and asked th give lenient bond terms.

The case is coming up for h September 7, 8 and 9, 2005.

The offence of unlawfull unborn babies is bailable, but maximum of life imprisonment

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

The purpose of this section is to discuss the qualitative approach applied to the design, gathering and analysis of data for this study. The study was conducted in Mombasa City and the Kilifi District of Coast Province, Kenya from April to July 2005. Outlined also are the ethical concerns and major challenges and limitations of the study. Ethical Review Committees of three different institutions granted the study ethical clearance after a rigorous process that took almost one and a half years: the University of KwaZulu-Natal, the University of Nairobi/Kenyatta National Hospital and the World Health Organization.[29] Further ethical approval was granted by the Coast Provincial General Hospital review board. The study process observed strict ethical adherence and trod the territory with care and sensitivity because the privacy of the sexual experience, disapproval of premarital and extramarital sex and legal restrictions on abortion render the topic of study sensitive in nature.

3.2 Study Design

3.2.1 Interpretive inquiry: research design

Abortion is a medical and social phenomenon that invokes emotive and controversial debate in Kenya as in many parts of the world, with little attention given to the dilemmas facing women with unintended pregnancy, the way they define and understand their situations, how this impacts on abortion-seeking behaviour, and the phenomenal public health catastrophe. Based on constructionism epistemology, an interpretivism theoretical perspective guided by feminist

[29] The Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization provided financial support for the field activities after ethical approval by the Scientific Committee for Review/Research in Human Subjects (SCRIHS)

standpoint research design grounded the logic and criteria for the research process (Wallace and Wolf, 2005; Crotty, 2003). Feminist standpoint research methodology allows the use of women's voices to express their lived experiences of abortion (Liamputtong and Ezzy, 2005) and insights into their individual lifeworld. It facilitates exploration and moves abortion processes to the foreground. Thus the researcher gains a deep level of understanding of the abortion phenomenon from women's descriptions, meanings and perceptions provided in their abortion stories. The researcher then views these understandings against the backdrop of women's unique contexts and their social, economic, and cultural backgrounds. Hence, individual in-depth interviewing using empathetic dialogue and non-directive form of open-ended questioning were methods uniquely honed to collect rich and "dense" descriptions. These descriptions formed the ground from which substantive theory was abstracted.

As I found, interpretive inquiry is always value laden and the researcher is an intimate participant, an empathetic observer, reflective partner, and co-creator of meaning. Taking the "Verstehen" position ("insider" view) (Henning et al., 2004; Hennink & Hutter, 2004), I placed myself in the women's positions, grasping their subjective meanings of the phenomenon in order to understand how they make sense of their actions (Clandinin and Connelly, 2000; Weber, 1964 In: Frankfort-Nachmias and Nachmias, 2006) and the interpretations they use to make sense of their social settings. Significant is the view that women's worlds are made up of multifaceted realities that are best studied as a whole, recognising the significance of the context in which the abortion experience occurs. Knowledge of the experience of abortion is constructed not only by observable phenomena, but also by careful descriptions of the women's intentions, beliefs, values and reasons, the meaning they impart to situations in everyday life and self-understanding (Henning 2004; Wallace and Wolf, 2005; Clandinin and Connelly, 2000). Women's social location by class, age, marital status, ethnicity, religion and their global location profoundly affect the abortion process.

Multiple factors come into play when women make the decision to have an abortion and the diverse routes followed are complex. The above perspective informed the purposefully selected team of interviewers and the data collection procedures, analysis, and writing, each of which are discussed in that order below.

3.2.2 The research team and their role

A team, comprised of three female research interviewers and I, was involved in the data collection process. Part of the important criteria in the recruitment, conducted by myself, was that the research interviewers should be persons that respect women's reproductive health choices, therefore non-judgmental in their views of abortion. Of the three female research interviewers I recruited, two were university graduates (B.A Sociology and B.A Languages/Linguistics). Both were unmarried, childless, and grew up in the Mijikenda community, therefore they had a good knowledge of the culture and languages of the Giriama and the Chonyi, the majority inhabitants of Kilifi district. They also had previous training and experience in qualitative data collection, tape recording, transcribing, translation, and ethics in human research gained by working for international health research organisations based in Mombasa and the Kilifi district. One of them had been involved in a similarly sensitive project on sex workers in the Coast Province. These two research interviewers conducted, transcribed and translated all the interviews (held in Mijikenda languages) with the women in the Kilifi district. I conducted a few interviews in Kiswahili or English languages with Kilifi women.

The third research interviewer was a young unmarried mother[30], 'O' Level graduate and an experienced Community Based Health Worker and counselor in family planning and HIV/AIDS within urban Mombasa. She grew up and was schooled in Mombasa, had a good command of local Kiswahili, and was conversant with both the student life and out-of-school life in Mombasa city through personal experience. Thus, the young urban women could easily identify with her. She and I (non- speakers of Mijikenda languages) conducted most of the interviews with women in Mombasa households and at the Coast Provincial General Hospital (CPGH). Most of the interviews in Mombasa City and at the CPGH were done in the Kiswahili language and a few in the English language as per the participants' preferences. Occasionally the two research interviewers in Kilifi joined us in Mombasa to assist with interviews. I also conducted almost all

[30] She was engaged to a young jobless man who was the father of her daughter. The man's parents had paid some dowry to her parents symbolising *kufunga mlango* literally translated as 'closing the door' meaning that no other man could propose to marry her. Although she lived with her parents, the boy's parents took responsibility for the welfare of the child until their son was economically able to take over family responsibility. This piece of information is important in understanding the coastal traditional practice in the management of pre-marital pregnancy discussed in Chapter Five.

key informant interviews (in Kiswahili or English languages) in Mombasa and the Kilifi districts and supervised the field study.

In addition, the research interviewers had been trained by me from 9th - 13th April 2005 at the Lotus Hotel, Mombasa guided by a training manual I had prepared. The content of the training programme entailed: (1) a thorough reading of the study protocol highlighting the goals and objectives; (2) a detailed description of the interview schedules with emphasis on confidentiality; (3) a language workshop for English/Kiswahili/Ki-Giriama compatibility to ensure standard use of concepts. We discussed the interview guides and the translated versions, and then made changes accordingly. (4) Ethical issues, informed consent, disclosure, confidentiality, privacy and anonymity, and the interviewers' role in ensuring strict adherence to these considerations. (5) Revised basic counseling skills and how to manage emotions arising from relived experiences, and (6) practical and mock empathetic dialogue, listening and probing skills.

With the help of the medical staff at the Coast General Provincial Hospital (CPGH), I recruited a professional nurse/counselor who worked in the obstetric ward but was on leave at the time to be part of the research team. The nurse had research experience gained from participating in other research projects on maternal health at the hospital. She was instrumental in providing post-abortion contraceptive counseling for women participants at the hospital and for recruiting potential women. As discussed below, it also became necessary to engage other medical and paramedical workers to assist in recruitment of potential participants in Mombasa and Kilifi households.

3.3 Data Collection Procedures

3.3.1 Research sites

The purposively selected research settings were located in Mombasa city (urban) and the Kilifi district (rural and peri-urban).[31] In Mombasa city, the three divisions covered were Mombasa Island (Tudor, Majengo, and Bondeni), Mombasa West mainland (Changamwe and Magongo)

[31] See CHAPTER FOUR: study setting in Mombasa city and the Kilifi district.

and Mombasa North mainland (Kisauni and Bamburi). In the Kilifi district, we covered four divisions, namely Kikambala, Chonyi, Bahari and Kaloleni. Recruitment sites around shopping centres located along the Mombasa-Nairobi and Mombasa-Malindi Highways were classified as Kilifi peri-urban and the more remote sites as Kilifi rural. Recruitment of potential participants took place in households, youth groups, and public and private health facilities. Public health facilities visited included the Kilifi District Hospital (KDH), Ngerenya Health Centre, Mariakani sub-District Hospital, Rabai Health Centre, and the St. Luke's Mission Hospital in Kaloleni. In Mombasa City, public health facilities visited were the Mombasa District hospital, and the Coast Provincial General Hospital (CPGH). The CPGH is the provincial referral and medical training hospital located in Mombasa City and has the highest turnover of women seeking treatment for complications arising from abortion. The research sites were broadened after noting that interviews yielded little information on induced abortion experiences compared to spontaneous abortion.

3.3.2 Entry in the research sites

Abortion being a public health matter, entry to the research settings was through the Ministry of Health[32] (MoH) and reproductive health non-governmental organisations (NGOs) concerned with population health which work in collaboration with the MoH. At provincial level, the Provincial Medical Officer of Health (PMOH), the Chief Administrator, Coast Provincial General Hospital (CPGH) and the Provincial Obstetrician/Gynaecologist granted authorising approval. Thereafter, I held a series of preliminary meetings with the sister-in-charge of the ward where recruitment and interviewing would take place. At the district level, the Medical Officer of Health (MOH) at the Mombasa District Hospital (MDH), (which was then located in Port Reitz[33]) and the Kilifi MOH were instrumental in introducing the research team to selected members of the District Health Management Teams (DHMTs) – The District Public Health Nurse (DPHN) and the District Public Health Officer (DPHO). The Kilifi MOH also linked the research team with other public and mission health facilities within the districts that would form

[32] The Ministry of Health and the Mombasa Municipality have parallel structures of urban health administration. We chose to work with public health facilities that were under the Ministry of Health because they provided post-abortion care services. Then there is the private health sector; they too participated in the study.

[33] The hospital is currently known as Kilindini District Hospital. Similarly, what was formerly the Tudor Health Centre is now the Mombasa District Hospital. These changes follow the 2008 administrative divisions that split Mombasa district to create Kilindini district.

part of our recruitment sites. The DHMT further linked the study team with private practitioners. They were certain that private practitioners who complied with the Ministry of Health (MoH) guidelines of health standards, safety and quality service provision, would be willing to participate in the study. The DHMT worked closely with and supported private practitioners who observed expected medical standards. Indeed, after presenting the study purpose to private providers, the response was overwhelmingly positive and many welcomed the study. Several of them volunteered to recruit potential participants who may seek unrelated health services. In this way, they became "field assistants". One provider followed me after the study presentation and volunteered to be a study participant herself, in addition to assisting in recruitment as a "field assistant".

Kilifi household entry was facilitated via the Public Health Technicians (PHTs) who introduced the research team to the Health Centres (HCs), and the local administration (location[34] Chief and sub-Chief). The area Chief arranged for a special meeting with village elders and various committee leaders of community projects. The elders had the time to ask questions concerning the study and we answered these to their satisfaction. This helped garner their support and they assured the study team of community support and safety while in the field. They also committed themselves to spreading the word about our research project around the households in the area to avoid suspicion. The community elder suggested the inclusion of a female member of the community health committee, that is, a community health worker (CHW) who would identify potential households for interviews and walk with the team through the villages. She became a field assistant too. She was conversant with local happenings, of good repute, and trusted by the community.

Mombasa household entry was a challenge. The private residential urban setting with culturally heterogeneous communities was not easily approachable compared to the culturally homogeneous communities in the rural settings in Kilifi. Individuals in various reproductive health NGOs working to promote women's and youth health in the communities facilitated introductions to youth groups in order to reach potential women participants. I held discussions with the youths during their regular meetings to explain the purpose of the study. Following

[34] Actual locations remain anonymous for confidentiality.

these discussions, I left my cell phone number so that those willing to participate could easily contact me. After that initial meeting, one of the youth followed me to volunteer to be a study participant saying "I want to be the first person you interview. This thing has really been burning my heart and as I listened to you talk, I felt I want to share it with you." I was to learn later that Binti Francie was a newly married nulliparous woman and a volunteer community health counsellor for the youth with years of experience in youth reproductive health matters. She was familiar with the intricate cultures of the urban communities and, as a field assistant, became instrumental in recruitment of potential participants.

3.3.3 Study population

One hundred and eight (108) women of diverse backgrounds participated in individual interviews. Women who reported on induced and spontaneous abortions were 49 and 59 respectively. I analysed induced abortion transcripts (49) only to answer questions relevant for this study. Mombasa (29) and Kilifi (16) households yielded 45 women with self -reported induced abortions and stopped the interviews because the information reached saturation point. At this point, I observed that new cases yielded no new data; instead there was repetition of the same information provided by earlier participants. The data yields from health facilities were poor. Only four women with reported induced abortions were from a public health facility, the Coast Provincial General Hospital (CPGH). It was difficult to recruit women on treatment for abortion-related complications in district hospitals and health centres (HCs) because most of them received treatment and were discharged on the same day. By contrast, most women seeking treatment for abortion-related complications at the CPGH stayed for longer than a day; therefore we had time to recruit them. This difference in length of stay between the CPGH and district hospitals or HCs may be explained by the varying MVA costs and mode of payment. While the CPGH charged KES 1, 500 per MVA payable upfront, the district hospitals charged half the amount after offering services and this was often waived. HCs offered free MVA services.

3.3.4 Sampling technique

The selection was purposive in order to increase the chances of obtaining diverse individuals who had aborted at least once. Purposive selection may be referred to as 'judgmental' sampling (Rubin and Babbies, 1993) where the researcher exercises his or her judgment in selecting the

sample on the basis of his/her knowledge of the population (Sewpaul, 1996:33). Recruitment, done by the field assistants, myself and the research interviewers, targeted women with a self-identified pregnancy or birth history who gave informed consent to participate. This team found potential participants in households, youth groups, and women admitted to hospital for post-abortion care, and those seeking unrelated health services in health centres or clinics.

Pregnancy histories helped to identify potential study participants, that is, women who reported pregnancy losses (induced or spontaneous abortion). These we obtained from women volunteers via a brief questionnaire[35] on pregnancy history contained on the first page of the interview guides. Where a woman in the household reported nil abortion (induced or spontaneous) history, the interviewer carefully switched to general questions fit for a key informant as opposed to depth interviews for personal experience. The switch between individual in-depth interviewing and key informant interviewing helped to provide cover for women in households reporting induced abortion (Ganatra and Hirve, 2002:77). This strategy ensured the community did not view the investigation as an "abortion study" and the women participants as "abortion seekers". In this way, we were careful to protect women participants from community stigma. In some cases, the field assistants informed the interviewer if a woman booked for interview had a history of induced abortion or not. However, this information remained confidential and the interviewer never told the research participant that she knew. The interviewer relied on the obstetric history provided by the research participant. Only when a woman disclosed an induced abortion experience did discussions narrow and probe the issue. Ganatra and Hirve (2002:77) applied a similar recruitment strategy in the villages of rural Maharashtra, India.

Purposive selection in health facilities, sometimes guided by first-hand observation by myself of circumstances surrounding women's arrival at the reception desk in the gynaecological ward for admission, clinical examination, and open interview of patient by the medical staff for clinical history, was valuable in increasing the chances of recruiting women with experience of an induced abortion. The public hospital lacked privacy and the nurse took women's clinical

[35] Questionnaire on pregnancy history extracted from the Kenya Demographic and Health Survey (CBS et al., 2004). See Appendix III: Interview Guides.

histories in the hearing of everyone present. The following piece taken directly from my field notes illustrates such observations:

Box 3-1 *Binti* Kamene's arrival at the Coast Provincial General Hospital (CPGH)

> 15H30: A young woman, *Binti* Kamene (pseudonym) on a medical trolley-bed is wheeled into the ward by a female nurse accompanied by a middle-aged man, who I later learnt from my interactions with her family is her mother's brother. The medical trolley-bed is parked by the reception desk where I am standing. The female nurse passes on the admission paperwork to the ward nurse on duty. The ward nurse interrogates the woman's uncle. He explains that his niece had told him she had had an abortion at some clinic whose name she had not revealed. It was while on treatment for abortion complications at the Mombasa district Hospital (Port-Reitz) that her family got to know; after her health condition deteriorated, the doctor referred her to the Coast Provincial General Hospital (CPGH) by ambulance. The ward nurse interrogates the young woman "*ulienda wapi kuchokorwa mimba*"? (Where did you go to have the pregnancy aborted?). The young woman faintly responds to questions. The ward nurse calls the medical doctor on duty who on arrival examines the clinical notes and concludes that urgent surgery is needed. A few internal calls confirm that the chief surgeon and gynaecologist are not available. They were tired after long hours of theatre. In the meantime, the doctor prescribes antibiotics to arrest infection, pending surgery the next day. The woman is taken to the ward bed. I chat with the uncle. He explains that her mother waited outside but was not informed of the real cause of illness, to protect her from shock because she suffers 'pressure' (hypertension). Uncle appeals for help in treatment and urges me to interrogate his niece in order to know the clinic where abortion was done so that the family can report the provider to the police. The uncle also requested contraceptive counseling to his niece to avoid repeat abortion. I briefly chat with his niece. She informed me that a friend had directed her to a "back-street" abortionist. She had complications after which neighbours took her to the district hospital.

Source: Field notes/*Binti* Kamene/CPGH/170505/PI

I noted with interest that the nature of these observed circumstances provided clear indications of an induced or spontaneous abortion. Some circumstances were more obscure than this. For example, 'Good Samaritans' (neighbours or friends who volunteered to help) who escorted the young woman to the ward took off immediately, and did not follow-up on her progress. This was a common occurrence among cases I suspected to have 'probably induced abortion'.

Recruitment of women participants from households was a difficult job because reproductive health information is regarded as essentially private. In addition, the Kilifi rural community was suspicious and resistant when it came to the promotion of any health strategy, be it a campaign for malaria, measles and, worse still, a family planning-related talk, noted the Public Health

Nurse. Field assistants (CHWs, PHTs, youth counselors) went round the households on a weekly basis, recruited volunteers and set appointment dates for interview. On the appointment dates she accompanied the interviewers to the households or venue and stayed within the vicinity until all appointments for that day were done. Our experience showed that women in households and youth groups willingly volunteered to participate in the study because a 'health expert' who they trusted approached them. In a few instances, women participants recruited from youth groups in Mombasa in turn recruited friends who were willing to participate in the study. This ripple effect, which happened without our prompting, ensured successful recruitment of participants who had had an abortion.

The intention of the recruitment strategy was to capture as wide a range as possible of experiences from a broad spectrum of women in order to cover varied experiences of abortion. Background characteristics included information on the area of residence, economic activity, and years of schooling, marital status, religious affiliation, and age. This information formed the last page of the interview guides and was obtained at the end of the interview. Where field assistants identified potential study participants, they obtained the women's first verbal consent. The field assistants separately read to each potential woman participant the appropriate informed consent form[36] and answered any questions after which a woman would verbally indicate her willingness or otherwise. Once a woman, with full knowledge of the study objective and risks, had voluntarily agreed to participate in the study, the field assistant introduced her to the interviewer. The interviewing researcher then made interview arrangements and sought verbal informed consent for a second time before the interview and recording it on tape, started.

3.3.5 Ethical Considerations

3.3.5.1 Informed decision-making and confidentiality

As noted repeatedly, the subject of abortion is extremely personal, often kept strictly secret and is usually emotionally distressing. The study observed sensitivity to the need for privacy, confidentiality, anonymity and informed consent (WHO, 2003b; Ulin et al., 2002). I had the obligation to respect the rights, needs, values and desires of women (Creswell, 1996: 201) in order to win over the communities, health service providers, and other institutions. Participation

[36] See Appendix II: Informed consent Forms

in this study was voluntary. Before participants took part in the research they had to give verbal informed consent after reading the form I had designed for this purpose. I (or my research assistants) approached prospective research participants individually and in private and explained the purpose of the study as per the disclosure document/consent form. I accepted no pre-condition demanding sharing of confidential information or details that could be used to trace participants. In one of the rural villages, I had to decline participation of a volunteer participant (under 18 years and unmarried) who had had an abortion and was pregnant at the time, and whose parents had given consent for interview, but her brothers had insisted on being present so that they could listen to the kind of interview questions asked of their sister.

Women had the right to withdraw from this study at any time without any consequences to their entitlement to standard medical care. Interviewers made no record of name, identity number, address, or phone number that might connect the participants to the information they provided. Before recording any information on tape, interviewers sought permission from the respondent. Other than public health facilities and institutions, this document has camouflaged the identity of organisations and the private practitioners, participating communities and specific localities. I will destroy all the raw data after study completion and writing several academic papers.

3.3.5.2 Risk-benefit assessment

Interviewers spelt out the risks and benefits to participants. Participation in this study did involve psychological and emotional disturbance as well as an invasion of privacy of the participants. The interviewer was a co-participant and observer invading the life of the informant as she revealed sensitive personal information. This is of particular concern given the moral, religious and legal restrictions attached to the abortion issue. It also involved taking up of about an hour (in some cases more) of the participants' time. As part of the benefits to study participation, all women were encouraged to discuss any reproductive health concerns they had with the research team who willingly shared information with them and advised them on appropriate referrals where necessary. Post-abortion counseling services were available to all women participants in the health facilities. However, none of the household participants requested counseling beyond what the interviewer provided. Surprisingly, some women who had experienced abortion in the

distant past felt that the interview was therapeutic, provided them with an opportunity to share a 'secret' they had long held.

3.3.6 Research instruments

Interviewers used semi-structured interview guides to gather information from primary sources (women participants who reported abortion, induced or spontaneous) and secondary sources (women who reported no abortion and other key informants). The interview guides had English, Ki-Swahili, Ki-Chonyi and Ki-Giriama versions. The original guides I developed in the English language and then translated them in to the Ki-Swahili language. An independent translator conversant with spoken Ki-Swahili in the coastal region verified the translation and made appropriate corrections. A hired female translator from the Mijikenda community further translated these from Ki-Swahili/English to Ki-Chonyi and Ki-Giriama languages. The initial study design had two distinct in-depth interview guides: one for women recruited in health facilities and another for those recruited in households. The household interview guide captured a broader reproductive health history than the health facility one. The assumption was that the health facility interview guide directly targeted a "live abortion" experience and the health facility environment was more protective than the household as family members were absent. On the other hand, the household interview guide tried to capture a "historical abortion" experience.

However, lessons learnt from the pilot study led to the conclusion that having one interview guide (the household one) sufficed. This was because in either case, the pregnancy/obstetric history were appropriate for introducing the interview. It was the pregnancy history the woman provided and her willingness to disclose whether she had an abortion or not and that the abortion was voluntary, which determined the direction of the interview thereafter.

The pilot also helped assess appropriate translation of questions and question order; reliability and validity of the responses; an indication of how long each interview might take; advice on appropriate places for conducting the interviews; the effectiveness of the interviewers in eliciting information; and the counseling needs of the respondents. We assessed the weaknesses and strengths of recorded interviews and consistency of data during pilot fieldwork. The research

interviewers made additional changes to the interview guides and this adjustment process continued during the fieldwork.

The first part of the interview guide contained, apart from an opening statement, key demographic questions relating to the reproductive and obstetric history of the woman including family planning knowledge, attitude, practice, and gestation age, maternal age, parity, and marital status at abortion derived from the Kenya Demographic and Health Survey (CBS et al., 2003); in addition, the years of schooling and occupation at the time of abortion; norms and religious beliefs; the second part covered the deeper topics of personal experience of abortion and decision-making for the procedure. Other details included technological, competence and institutional setting (Adeokun, 1991) issues such as sanitary conditions at the abortionist clinic, description of methods and tools used, provider competence, complications encountered, and subsequent management of these. Discussions also sought to elicit women's awareness of abortion incidences in the neighbourhood, current perceptions of abortion, and their views on the abortion law. The social demographic characteristics of women at the time of interview such as age, marital status, years of schooling, and occupation were captured separately at the end of each interview session. However, due to the flexibility of the interview, reference to the interview guide was only occasional to satisfy the interviewer that she had covered all topics. Since in most cases data were retrospective (the experience of abortion was in the past), the background characteristics of the woman and her situation at the time of abortion, informs the contextual analysis in the chapters ahead.

Discussions with selected key informants focused on community perception of contraceptive, incidences of abortion in the community, sources of unsafe abortion, consequences of pre- and extra-marital pregnancy and attitudes towards the existing national law regarding abortion. Key informants included selected health providers in public and private health facilities: traditional midwives, popularly known as *Wakunga* (or *Mkunga* in the singular), and a traditional healer; women who reported no abortion; individuals from reproductive health organizations; youth group members; the local administration; village elders, and members of village health committees. Others included head-teachers of a primary and secondary schools, the officer commanding police station; a Mombasa member of parliament, and a Kilifi Councillor.

3.3.7 Methods of data collection

Methods of data collection involved interviews, observations and hospital records as discussed below:

3.3.7.1 In-depth interviews

Interviews were the major type of data collection. Individual in-depth interviews are potent tools for gathering information about practices that are illegal, veiled in prohibitive silence and secrecy, associated with shame or immorality and heavily laden with strong personal, religious and cultural values (Helitzer-Allen et al., 1994 In: Nyanzi et al., 2005:155). These were conducted face-to- face with each individual woman. However, the interviews were not just tools for gathering information but involved creation of a social environment in which empathetic relations/ connections between the interviewers and interviewees (women) were being founded in order to gain depths of understanding into the women issue from an emic viewpoint. In cases where a woman reported an abortion history, the interviewer proceeded with in-depth interviewing to distinguish induced from spontaneous abortion (Rasch et al., 2000a). During the in-depth interviews, we created a non-threatening environment, free of moral judgment, thus making it possible for women to share their experiences (Rasch & Lyaruu, 2005:302).

Interviewers asked questions in an open-ended manner, and engaged in empathetic dialogue, without creating the impression that one way of doing things was better than any other (Henning, 2003:57; Rasch et al., 2000a). The friendly invitation to engage in a dialogue at the start of interview, which included the kind of small talk normal and acceptable in daily conversation in the community, and informal and relaxed seating arrangements made it easier for the women to share their deepest emotions and personal life experiences openly and freely. Where a woman had a child or children enquiry about their health helped to create a familiarity and build a comfortable environment. Certain questions such as marital status, which, if the woman was single, was a source of social stigma and judgment, we avoided until the very end of the interview unless the woman pre-empted it in the course of conversation. The interview remained deliberately flexible and in conversation style in order to allow women to express themselves

freely, and to develop ideas and speak broadly without being restricted to keeping strictly to the order of questions.

In a "dialogic communicative action" we carefully and sensitively probed and prompted women by encouraging them to elaborate and continue with certain points of interests for the study. Utterances such as "hmmm" were common prompts. The tone of voice and being a keen and interested listener, helped to capture private stories of pain, indignity, uncertainty, and fright that are easily lost in social surveys and tables of statistics (Potts et al., 1977: 11). As co-participants, interviewers immersed themselves in the narrations; walked and identified with women as they re-lived the events, sometimes extended a personal touch or embrace to express concern, care. This bonding in a sense created a trust relationship and influenced how women presented themselves, their accounts and how much in-depth into their private inner world they allowed the interviewers. Thus, interviewers' efforts at building up relationships meant that most women spoke openly about personal life experiences that were often private and perhaps being disclosed to a second party for the very first time. Perhaps this also explained the therapeutic feeling most women expressed after the interview. During the probes, the interviewers reminded all women about the available counseling services should they feel the need for it. However, disclosure of personal life experience did not come easily. For some women, especially those who had had the procedure done in the recent past, the narration invoked a lot of emotion and they cried in the course of interview. Interviewers were trained and able to handle these situations with empathy.

Although some women freely gave detailed accounts about their experience(s) others gave scanty responses which required more probing to obtain information. For example, it took a lot more questions for *Binti* Kadzo to provide as much information as *Binti* Riziki.

Box 3-2: Excerpt from *Binti* Kadzo's transcript

I: how old were you when you got the first pregnancy?
R: 17 years
I: Just tell me how that first pregnancy was.
R: The first pregnancy I aborted because I was in school.
I: how many months was it?
R: two
I: Tell me what you did
R: I went to another hospital there at home (referring to her rural home).

Source: *Binti* Kadzo's transcript/CPGH/190505/EM3

Box 3-3: Excerpt from *Binti* Riziki's transcript

I: When you first conceived how old were you?
R: nineteen years.
I: Tell me how the first pregnancy was.
R: When I got that first pregnancy, I realized I had conceived when it was three months old because I started getting sick. I started vomiting, feeling lazy and I do not eat well. I eat while in bed. So when I went to hospital I was told I have slight malaria and that I have a three month pregnancy and that doctor irritated me with his interrogation and then he asked me "now what have you decided?" I told him I am not decided until I get home that's when I will decide what to do.
I: And then?
R: So I came and stayed and when the pregnancy was four month I was still getting sick.
I started following that man and telling him "I have no money; give me I go to hospital". He would give me only one hundred shillings.

Source: *Binti* Riziki's transcript/CPGH/170505/EM3

Most women at the provincial referral hospital (CPGH) undergoing treatment for complications resulting from unsafe abortion avoided giving detailed descriptions of how they induced abortions and instead, implied that it was a spontaneous act while easily providing a vivid narration of a previous induced abortion, which I often suspected, was the current one but framed in the past. Similarly, some unmarried women at the CPGH would refer to the man responsible for pregnancy as 'husband' but as the interview proceeded, they would refer to the same man as 'boyfriend'. Society perceived induced abortions as a practice for unmarried women while associating spontaneous abortions with married women. A woman presenting as having a 'husband' intended to imply 'spontaneous abortion' to avoid moral judgment. In one instance, I observed a Muslim woman accompanied to the gynaecological ward by a male and female relatives. The medical staff later explained to me that the male relative had masqueraded as her husband to suggest that hers was a spontaneous abortion. Although probing helped to achieve clarification or obtain more information, I felt it to be important to respect the woman's decisions on how much she was willing to share of her experiences. Restrictions on abortion and the social stigma attached to it often made people reluctant to discuss the issue openly with researchers (WHO, 2003b; Warriner and Shah, 2006).

Interviewers encouraged women to ask questions at any point over and above the standard topics under investigation. If they did not ask any question in the course of interview, at the very end before the close of interview interviewers asked them to do so if they so wished. Questions most

frequently asked were in relation to their own reproductive health, and the common side effects of family planning methods.

The study conducted single interviews[37] best suited for this kind of topic to minimise the pain of women already put to the risk of reliving the experience. Privacy was also of paramount importance, and upheld in the single interviews. Nonetheless, interviewers made follow-up visits to the health facility (CPGH) where women were admitted for several days so that the interviews could take place in stages to gather all hospital experiences from the day of admission to the day of discharge. The days spent doing fieldwork in households were organised to take place every other day so that sufficient time was allocated for immediate transcription. Health facility interviews took place as prospective cases presented themselves, more commonly at the CPGH. In-depth interviews were the most useful method of data collection because the participants could not be directly observed. Unlike observations that yield "direct" data, interviews are limited in that they provide "indirect" information filtered through the views of women.

Interview venues: To ensure confidentiality, the venues for household interviews varied to ensure the woman's comfort. Most Kilifi household interviews were conducted either under a tree within the household compound or inside the house or kitchen, depending on the woman's choice. There were noise interferences from children, the wind from the Indian Ocean, and curious passers-by, who would shout greetings as they continued on their way. Most Mombasa household participants preferred interviews far away from their homes for the sake of privacy. These included the interviewer's house, the community hall, and the beachfront. Where a health provider facilitated the recruitment, they also provided a private room at the clinic from which the interview took place. Few interviews in Mombasa City took place in women's houses/homes.

Although I gave all participants a cash token to buy refreshments and pay for transport to and from home, women at the health facility received additional material benefit. For example, unmarried women on treatment for abortion-related complications often had no family to take care of them, and I found myself assuming the 'family' role in ensuring they had toiletries, and offered baskets of fruits after the interview. I also made efforts to follow up on their treatment

[37] Single interviews are done once without follow-up unless for special cases such as women in health facilities

progress and requested fee waivers for them on their discharge. The extent of help varied in each individual case; depending on the circumstance. In the Kilifi rural households, interviewers in turn enjoyed the African hospitality of *chai* (tea brew) or homemade fresh *mnazi* (palm wine) or coconut gifts to carry home.

Tape-recording: Each side (A and B) of the tape was labeled appropriately consisting of the interview type, abortion experience, age, field site, venue of interview, and date. Audiotape recordings of the interviews created an uneasy and often distracting environment for some participants. Women who had had abortions and were interviewed at either the health facility or the police post were least at ease with the tape recordings. This was despite the fact that they had consented to tape-recording before the start of the interview. Some feared we would air the information on radio or that the administrative authorities would have access to the recorded material. It is possible that some participants may have associated our recorder with the small portable radio commonly found in the local market, hence the link. To resolve this sensitive subject, I recommend smaller less intrusive pocket audiotapes that have the capacity to run for long hours as best suited for interviews. Even so, consent to record the interview must be obtained to ensure strict adherence to ethics.

3.3.7.2 Observations

As illustrated in the example above concerning the recruitment strategy in health facilities, observational notes were made in the course of the field study and during the interviews and were a useful tool to gather and augment information obtained in interviews. Interviewers took short field notes during such interviews to capture certain contextual factors that the tape recorder could not capture: gestures such as facial expressions, tone of voice, tears, change in tempo of speech and general body language, and I made accounts of general conversations on unwanted pregnancy and abortion heard in public spaces. These helped attribute meaning to the verbal communication with participants. The interviewers each had a notebook to jot down questions that needed revisiting in order to avoid omission in the course of the interview. I maintained a dated record of reflective notes of personal thoughts that included "feelings, hunches, problems, ideas, speculation, impressions and prejudices" (Creswell, 1996:189).

3.3.7.3 Documents and audiovisual materials

Records of women's clinical histories were at the team's disposal so I easily crosschecked information on background characteristics with the information women gave in the interviews. A couple in Kilifi, *Bi* Pendo and her husband, gave me a photograph for use in this study, despite my insistence that no identifiers would be recorded as the information collected were to be anonymous. The photograph showed *Bi* Pendo on treatment for abortion-related complications at a rural clinic and her husband seated by her bedside. As a commitment to ethical considerations this photograph is omitted in this document.

3.4 Data Analysis and Interpretation

"Good interpretive inquiry is data driven and should theorise, discuss data and conceptualize" (Henning et al., 2004:47). In total, there were 49 transcripts with lengths ranging between 3 – 12 pages per transcript that contained "thick description of the theme of study" (Henning et al., 2004:37). The QSR N6 (Nud.ist) facilitates management of large amounts of raw data transcripts (APHRC, 2004). I read and re-read the transcripts repeatedly until all the data patterns were intimately familiar to me. This facilitated quick development of categories using the software. The data analysis processes used here were guided by principles that have been identified as appropriate for most types of qualitative analysis (Smit, 2001 in: Henning et al., 2004:127). The content was analysed by coding and categorising the text then generating substantive theory in a process of inductive reasoning (Henning et al., 2004:41, 47). Cross tabulations, using MS Access, facilitated comparisons.

The process of data analysis went on in a back and forth manner throughout the data collection and transcription activities and throughout the extraction and construction of codes and categories, writing memos and the writing processes. Handling of the data records was managed to construct good explanations and predications from the emergent ideas, categories, concepts, themes, and hunches (Richards, 2005:1). The interviewers first transcribed taped interviews verbatim as per the local languages of interview, Ki-Chonyi, Ki-Giriama, and Ki-Swahili. Then the same interviewer translated the transcripts into English word for word. The full context of the

interview from audible tape and records from field notes were included on each transcript. Thus, silences, gestures, the mood, the venue, the background noises of vehicles, birds, mosques, other voices and other interruptions, presence of babies, the weather, time and length of the interview and other observations were captured. This was a tedious exercise which required a lot of patience. Most of this 'data' was useful in making an interpretation of the larger meaning to women's narrations. For example the sound of anguish, crying and repetitions captured in *Binti* Mercy's transcript illustrates her traumatised condition as she re-lived the abortion.

Box 3-4: Excerpt – *Binti* Mercy's transcript

> It is really disturbing; you can't even sleep at night! Aaaiii! its really painful, you just curse (crying). The only thing you can do is just curse! You curse everything (crying).

Source: *Binti* Mercy's transcript/ Kilifi peri-urban/010705/PI

Similarly, the laughter by *Bi* Rehema in response to the question seeking her views on the abortion law signifies indifference to the national law. This is further evidenced by her interrogation of how the national law fits into her social reality.

Box 3-5: Excerpt – *Bi* Rehema's transcript

> I: What is your opinion regarding the current abortion law that restricts people from aborting pregnancies?
>
> R: (Laughter)
>
> I: For now people are not allowed to abort unless you have a medical problem.
>
> R: They don't allow it? What if you have a problem like the child is getting weak who will help you to take care of him?

Source: *Bi* Rehema's transcript/ Kilifi rural/190605/KK2

Other background noises partly explained why some parts of the tape were indistinct or inaudible making transcription a painstaking exercise. I noted that the recording of interviews done in the open had much interference from the ocean winds and were therefore not very clear.

Interviewers tried their best to transcribe within the shortest time possible after the interviews to increase the chances of capturing every detail pertaining to the interview: the implication of some tone of voice, the background sounds or noise and so on. Interviewers labeled[38] each transcript to correspond with the audiotape cassette labels.

Due to lack of computer facilities during the field work, interviewers recorded, transcribed, and translated all data in long hand. On return to the University of KwaZulu-Natal, a hired secretary and I typed the transcripts into word processing documents to speed up the analysis process. I prepared all transcripts into text files and imported them into qualitative computer software for analysis (Nud.ist). As I worked through the data in the analysis process, each time I remembered the "heard" words of the women in my head, I found myself in tears, because for me these memories and transcripts were not just "data"; I saw the faces behind the sensitive data, and heard the women's voices vividly in the words, and I empathised with them.

Open coding, conceptually labeling units of meaning, was slow but thorough because I did it line by line, stayed close to the data and knew it well. The process of inductive making of meaning is interpretive. I categorised related codes, inductively naming similar incidents under the same conceptual labels. In "seeing the whole", (Henning et al., 2004; Richards, 2005) I made meaning of the relationship between these categories, the points they convey together and how they address the research questions. Comparing and contrasting these categories informed the extraction and construction of themes. Through the process of axial and selective coding I attached the conceptual labels to the segments of texts, and integrated and refined categories (theoretical sampling) to build theory from the data in the fashion of grounded theory construction (Henning et al., 2004:132).

The main propositions form the basis for argument, discussions and "findings" that explicate and explain social processes and phenomena in response to the research questions (Henning et al., 2004). The multiple perspectives of women are supported by diverse quotations and specific evidence. Literature is also used to advance argument. Theoretical models were constructed to

[38] I later replaced the label codes with pseudonyms to give them a human face and for easier reference in discussions.

describe and explain the processes. Finally, I made interpretations or lessons learned that call for action agendas for reform and change (Creswell 2003:195).

3.5 Validity and Reliability

The extensive and intensive literature review provided the basis to guide the entire study. The techniques and views of other qualitative researchers have greatly influenced the methodology, methods and writing style used. The research process was anchored in ethical rigor ensuring informed consent, privacy, confidentiality and anonymity. Data collection was done by skilled interviewers. To crosscheck "validity" (trustworthiness) and "reliability" (consistency) (Henning et al., 2004), an independent transcriber of Mijikenda origin transcribed sample tapes. Similarly, one of the interviewers analysed a sample of transcripts that helped me compare the themes with the themes I developed.

I monitored field activities and the research team in Kilifi provided me with telephone updates on a daily basis. In addition, weekly meetings in Mombasa every Saturday provided a good forum for team members to recount their experiences, discuss and adopt new strategies. The research assistants submitted translated transcripts of the previous week for confidential storage, and finally planned for the following week's activities.

3.6 Respondent Bias

Age reporting: The age at abortion was only an estimation based on the memory of the woman and there was no way of verifying this. Given the sensitive nature of abortion, age-at-abortion error was high. Similarly, some women, particularly those on treatment for abortion-related complications at the health facility (CPGH) preferred to discuss their previous abortion experiences and not the present ones. These women tended to report their present abortions as spontaneous, yet in most cases we suspected that the abortions were probably induced. I noted

other inconsistencies in obstetric histories, as well and information that required women to recall which year an event occurred such as their last year at school, the years children were born and so on. I attributed this to either memory lapse or low literacy levels among some of the women concerned.

Marital status: There was bias towards reporting 'married' status or serious relationships among unmarried women in health facilities. Perhaps this was due to the social stigma regarding premarital sex, fear of anticipated retribution by medical staff and other legal repercussions. This being a retrospective study, the above data were important in understanding the circumstances of the woman at the time of abortion and capturing repeat abortions. I conjectured that women's circumstances are connected to their choices for abortion and the types of abortion they experienced.

3.7 Challenges Presented by the Study

Non-disclosure of induced abortion experiences was the greatest challenge in the study, more so at health facilities than at household level. Although observational evidence at the CPGH provided pointers to an induced abortion case, women volunteers would still not disclose to the interviewer that they had had induced abortion. This partly explained why of the total 32 women participants at the health facilities only four women at the CPGH reported directly that they had induced abortion! This shows just how complex the study can be.

Mid-way through our fieldwork two events occurred at the provincial hospital (CPGH) that might have increased non- disclosure. The first was that there was a national strike by nurses over salary increment and better working conditions in the hospitals. The resulting shortage of medical staff prompted transfers of women from the gynaecological ward to the general female ward. The second event occurred during this strike period. The ward had a three day twenty-four hour police presence guarding a young woman admitted to the ward for the treatment of gynaecological complications. A chat with the police revealed that the woman was from a police cell charged with "concealing birth". The police presence might have created fear and negatively

affected women's willingness to participate in the study. For example, *Binti* Kamene had on arrival in the gynaecological ward narrated to me her experience of induced abortion in a "backstreet" clinic. Diagnosis of her complications revealed a ruptured uterus and sepsis that caused her to fall into a coma necessitating admission to a high dependency unit (HDU) for four days following surgery. After recovery, *Binti* Kamene was transferred from the HDU to the general female ward due to the nurses' strike. In a follow-up interview with *Binti* Kamene after the strike was over, she changed her story attributing her abortion to some self-prescribed quinine drugs with the intention of treating malaria. This second version of her story did not fit in with the complications she had experienced. I felt convinced that the police presence may have influenced her second version and her concerns about the tape-recorder, which she referred to as 'radio'.

The other two women at the CPGH, *Binti* Riziki and *Binti* Kadzo, who had induced abortion, gave vague and contradictory explanations about the circumstances that led to the abortion suggesting it was spontaneous, not intentional "I had gone to fetch water and fell with the container full of water; and I was helplessly sick; I had malaria so I took some tablets". In such cases, observational evidence came in useful and prompted careful probing during interviewing. For example, neighbours whom unmarried women referred to as relatives had assisted *Binti* Riziki and *Binti* Kadzo to hospital and no family visited them later, suggesting induced abortion.

Rich cultural connotations and ambiguities are lost in the translations from the local languages of ki-Giriama and Ki-Swahili to the required foreign English language of this document.

3.8 Lessons Learned/Conclusion

Unless there is a specific reason for doing so, demarcating a small area for study coverage for this kind of study, as I had outlined in the initial research proposal, can be frustrating. The Kilifi field experience taught me that by broadening the study area coverage we increased chances of capturing women interviewees who were willing to volunteer information. The two interviewers in Kilifi observed that the Chonyi women were more conservative in discussing their

reproductive experiences than were the Giriama women. The interviewers belonged to the Mijikenda culture, therefore were able to pick up these differences quickly after conducting a few interviews. The lesson thence is that abortion studies in conservative communities might not yield results. Understanding the study communities is important and underscores the need for ethnographic investigation to inform heterogeneity in reproductive experiences.

Recruitment of potential participants by resource persons (health providers, paramedical workers) trusted and regarded as 'expert' by the community, worked best in both rural and urban households and did not raise ethical concerns for the participants and the research team. As mentioned earlier, key informants suggested this recruitment approach. However, I cannot rule out the possibility that transferring a recruited participant from the resource persons to the interviewers may have affected the quality of information gathered, particularly in the health facilities, due to a "breach in confidentiality". The negative effect of the recruitment process was most evident in the case of health facilities. For example, if the recruiting nurse at the CPGH was also the interviewer, the quality and 'denseness' of information (completeness) and the number of women in the hospital reporting induced abortion might have improved. Identifying induced abortion by married women in health facilities was difficult because of the social bias that associates the procedure with unmarried women. Also, the more recent the abortion, the more emotionally difficult it was for women to narrate the experience.

The study attracted a lot of attention in the ward such that women not selected for interviews were demanding to be involved in the study as they thought it was about family planning counseling and discussions about other reproductive concerns. This to me was a clear indication of the huge demand by individual women for reproductive attention in public hospitals.

Some formal private health providers were willing to participate in the study as interviewees and as resource persons. As women and mothers they too have lived experiences of abortion and as providers (including the male) are affected by the issue through their clients and the law. For reasons related to confidentiality, women found it easier to disclose their abortion experiences to private rather than public health providers.

3.9 Summary and Conclusion

In this chapter, the methodology and methods guiding this investigation are discussed in detail. The nature of the qualitative approach lends itself easily to conducting an inquiry into an otherwise very sensitive and subterranean issue. It was observed that data analysis was an on-going back and forth process that included writing. By the time the data analysis and interpretation were complete much of the writing was done too. The four data chapters ahead are divided according to the questions of interest in this investigation. But first I present the context of the study sites, Mombasa City and the Kilifi district, useful for understanding the phenomenon of unwanted pregnancy and consequent abortion.

CHAPTER FOUR

4.0 STUDY SETTING: MOMBASA CITY AND THE KILIFI DISTRICT

4.1 Introduction

This chapter presents an overview of the study setting in Mombasa City and the Kilifi district.[39] The study covered only a few divisions in the two areas. Outlined are the physical, demographic, economic, social and health profiles that constitute the milieu within which women interact, and that shape their overall experiences with unwanted pregnancy and abortion. The social context is discussed with a gender lens in order to foreground the inequities that impinge on women's sexual and reproductive lives. Thus, the concepts of gender and motherhood are invoked to explore these different contexts. The 2002-2008 District Development Plans with the theme "effective management for sustainable economic growth and poverty reduction" provide the roadmap towards achieving development targets in the districts and subsequently the millennium development goals (MDGs); and the Ministry of Public Health and Sanitation Strategic Plan (2008-2012). This chapter draws immensely from these documents.

4.2 Geography

Mombasa City and the Kilifi district are uniquely located on the coastline of the Indian Ocean. The two make up the 13 districts[40] in the Coast Province. Mombasa is the second largest city after Nairobi, Kenya's capital city. Out of the four administrative units in Mombasa, the study covered three namely, the Island, Changamwe, (Mombasa West mainland) and Kisauni

[39] See Figures 4-2 and 4-3 at the end of this chapter.
[40] Recently, (2008) the government split Mombasa district to create Kilindini district. The Port Reitz hospital in Changamwe division served as the district hospital at the time of the study but is now in Kilindini district. In turn, the Tudor Health Centre in Island division upgraded to a district hospital to serve Mombasa district.

(Mombasa North mainland) divisions. In Kilifi, the study covered the Kikambala, Bahari, Chonyi and Kaloleni divisions.

The duration of the data collection (April-July), coincided with the long rainy season when ailments such as malaria fever, influenza and colds are at their highest. The Kilifi women and their children were busy preparing land in readiness for sowing seeds, and we watched them weeding and later, enjoying the first fruits of their green crop. Maize, beans and cassava are the main subsistence crops. However, rainfall in Kilifi is often unreliable resulting in widespread food shortages as crops fail due to either inundation or drought. The Kilifi rural livelihood system of subsistence farming is unviable due to changing climatic conditions and failure by the government to implement existing rural development strategies (KDDP, 2001). Despite the chronic food insecurity, Kilifi is naturally rich in coconut and cashew nut trees, mangoes and a variety of other fruit trees. Vegetation grows naturally and fish varieties among other sea creatures abound. While these provide easy income for the family and revenue for the districts, rural development strategies have failed to empower or support communities to create cottage industries to alleviate chronic food shortage and rampant poverty.

4.3 Population

The projected population of Kenya by 2003 was estimated at 32.2 million and that of the Kilifi district at 719 466 people by 2008 (CBS, 2002). The Kilifi inhabitants, the Mijikenda,[41] are largely rural (80%). High male rural-urban out-migration in Kilifi has meant the female population is higher (52%) compared to the male (47.5%). Nearly half the total rural population comprises children below 15 years of age (KDDP, 2001: 27). Mombasa is a cosmopolitan city receiving economic migrants and had a 2008 projected population estimated at 920 313 with the male (54%) exceeding the females (45%) (MDDP, 2001: 21). The population growth rate is high

[41] The Mijikenda are one of 42 ethnic groups in Kenya with languages that are, largely, mutually intelligible and closely related to Ki-Swahili. The Mijikenda (meaning 'nine villages') comprises nine Bantu tribes namely, the Rabai, the Chonyi, the Giriama, the Kauma, the Digo, the Duruma, the Jibana, the Kauma, the Ribe and the Kambe. They occupy the 'nyika' or coastal plains of the Coast Province and apart from the Digo and the Duruma, the rest of the Mijikenda spread across Kilifi district. They live in settlements or fortified villages traditionally known as 'kaya'. Some Mijikenda like the Chonyi and the Giriama are patrilineal (Mwangudza, 1983: 3).

at 3.6% (Mombasa District Strategic Plan 2005-2010) Male in-migrants in Mombasa engaging in extra-marital affairs with urban women and failing to send remittances to their rural families is a common occurrence. The Swahilis[42] are indigenous Mombasa inhabitants. The dominant religion in Kilifi and Mombasa is Islam followed by Christianity; a few rural dwellers practice traditional religions and some are agnostic.

4.4 Economy and Poverty Status

> "The Millennium Development Goals,[43] particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning".[44]

Kenya's economy has been unable to create jobs to meet the fast growing number of people seeking employment. This has caused an upsurge in poverty with about 56% of the population living in poverty and with over half living below the absolute poverty level (CBS et al., 2003; KNBS and ICF Macro, 2010). This is despite the wealth of resources that exist in the country. Rapid population growth and urbanisation are great contributors to poverty. The marginalisation of the Kilifi rural is historical and typical of rural areas in Kenya, which host almost 80% of Kenyans, but remain severely underdeveloped. This is despite four decades of independence and numerous but fruitless district development and strategic plans that dutifully prioritise construction of road networks, electrification, and water and health infrastructures to promote industrialisation and commercial activities and consequent socioeconomic development (KDDP, 2001). An expanded health service delivery network is dependent on an integrated infrastructural development (KDDP, 2001).

[42] The Swahilis are coastals who have a mix of Arabic blood and speak Ki-Swahili language mainly.
[43] The Millennium Development Goals are the overarching international framework for trying to alleviate the suffering of the poorest people in the world". Jeffrey Sachs, Special Adviser to the Secretary-General on the MDGs, 2002
[44] United Nations Secretary-General Kofi Annan, 2002

Poverty exacerbates ill health (and vice versa), and in particular, poor reproductive health. The Mombasa and Kilifi districts are good illustrative examples of this. Kilifi is considered a "less developed district" as the health and demographic indicators are relatively unfavourable. The persistently high Infant Mortality Rate[45] (IMR 110/1000) and the high maternal mortality levels indicate a low socio-economic status and the low status of women respectively. Among the Kilifi and Mombasa adults, about 67% and 38% respectively live in absolute poverty, meaning they cannot meet the minimum cost of food and other essentials for human life (KDDP, 2001). Most residents of Mombasa live as squatters, are unemployed or earn low incomes, and lack experience and skills. Poverty and related ills influence motherhood and reproductive decisions with implications for unwanted pregnancy and abortion.

The setting of these coastal towns while providing high economic prospects, are laden with opportunities for casual sex. The two important economic industries in the Coast Province and nationally, namely import/export and tourism, are huge foreign exchange earners, but inadvertently create complex dynamics for reproductive health. Mombasa's busy Kilindini harbour handles large tonnes of cargo daily. The haulage and subsequent transportation of containers takes place by rail and via the Mombasa-Nairobi Highway[46] to upcountry and eastern African countries. The harbour is the largest employer of casual and permanent workers in the Coast Province. It attracts people of varied socioeconomic and cultural backgrounds from all over the country and across the borders. The Mombasa harbour is visited by cruise-ships, and receives large numbers of international sailors with foreign exchange to spend on sex with local women and men. Mombasa and to a lesser extent, Kilifi, are famous leisure holiday resorts with hospitable residents who host large numbers of tourists yearly. Documentation exists that besides other officially known reasons, clandestine tourism prostitution attracts tourists to the Kenyan Coast (Omondi, 2003:3; UNICEF, 2001). The mushrooming foreign-owned brothels and private cottages are evidence of tourism prostitution as a core business (Omondi, 2003:7).

[45] The national IMR average of 52/1000 is already unacceptably high.
[46] The Mombasa-Nairobi Highway is part of the Great North Road corridor.

The myriad beach hotels of international standard, tour and travel companies, entertainment clubs, diverse cultural and historical sites and museums, and national parks and game reserves together with an international airport, not only provide employment, but also provide a climate for the interaction of multitudes of people (national and international) on a daily basis. Moreover, being a gateway to the country, there is daily high mobility in and out of the city. The presence of a foreign (US) military base adds to the influx of foreigners engaging in sexual exploitation of economically desperate communities in the coastal towns of Mombasa, Kilifi, Malindi and Lamu. Therefore, economic migrants and the highly mobile businesspersons and other professionals, tourists, sailors and military men find opportunities to engage in a culture of sexual convenience devoid of responsibility or penalty with consequences that may result in unwanted pregnancies, among other health risks. These 'away from home' conditions provide social anonymity, and a shield from social controls of sexual behaviour (Izugbara, 2008:35; Omondi, 2003:8).

Concentration of economic activities and infrastructural services along the Mombasa-Nairobi and Mombasa-Malindi highways has led to population densities being highest along these highways. Scores of women and men earn their living as sex workers along the major highways. It is common to find a 'couple' that lives off the woman's income from sex work. On the Mombasa-Nairobi highway, the sex trade with truck drivers thrives, while on the Mombasa-Malindi highway[47] sex tourism is a booming business (KDDP, 2001; Omondi, 2003; UNICEF, 2001). Chronic food shortages and abject poverty have led children (minors under 18 years of age) from desperate families to be sexually exploited by tourists. Several studies have revealed cases of children engaged in sex tourism trafficking across international borders, some with the full knowledge of their parents or guardians (UNICEF, 2001).[48] Child prostitution is an emerging trend affecting orphaned children whose numbers are increasing because of the HIV/AIDS pandemic. Indeed, many young up-country women job-seekers are lured to the coastal town of Mombasa with the promise that it is easy to get jobs only to get inducted in to the lucrative sex industry.

[47] Mariakani in Kaloleni, Kilifi district has a weighbridge for trucks, as they exit Mombasa. Long queues of trucks are characteristic of the small town. Cash in pocket, truck drivers lodge here on transit.
[48] See Figure 4-1 at the end of this chapter.

Drug barons operate surreptitiously and large numbers of idle youth abuse drugs. Abuse of drugs may be associated with irresponsible sexual behaviour leading to unwanted pregnancies. In addition, the Kilifi and Mombasa districts have high HIV and AIDS prevalence: 10% and 16% respectively among mothers attending antenatal clinics (KDDP, 2001). These complex situations signify a probable increase in desire to abort and the compromise of women's health. Yet in the last five decades since independence the health system has been unable to meet these increasing health demands, not to mention the attendant stigma. Certainly, there is need to change the situation for women by creating more egalitarian social structures as they form the backbone of the economy.

4.5 Socio-Cultural Values

In the study settings, a patriarchal society, motherhood is nearly a rule. By the end of their child bearing years, nearly all Kenyan women have given birth (KNBS and ICF Macro, 2010). Societal norms demand that child bearing take place in acceptable heterosexual marriage. In the rural settings of this study, most women do their primary mothering duties along with other tasks such as housework, subsistence farming and, small scale trading. In the city, most households are nuclear and isolated from kin. Women have total responsibility for children and despite their participation in the labour force, few earn enough to support themselves and their children adequately therefore often depend on men. Parents are obliged to take children, including girls, to school in line with the basic rights of the child. Although traditional marginalization in access to education, early marriage and childbearing persist, they, along with having sexual relations with minors (below age 18 years) are acts now punishable by the laws of Kenya. While in the past children were viewed as assets in terms of free labour, they have become consumption goods, expensive to rear.

Most families' daily struggle for survival and women's multiple roles make mothering a big burden. The number of single women with children, some of whom have never married, is on the rise. The mothering experiences of these unmarried women certainly differ from those of their ever married counterparts. In the same way, maternal experiences will vary by class and

occupation, factors that have influence on access to health care and related technologies. Child care support by the Government of Kenya is non-existent. The new law (Constitution of Kenya, 2010) provides a window of opportunity to address these inequalities, an indication of the increasing recognition that women should have equal rights. Understanding personal abortion experiences of women from a gender perspective is imperative in a society that is patriarchal, capitalistic and that essentializes motherhood.

Most women have little control over household resources, their household burdens notwithstanding. To augment household income, contemporary women engage in "public" domain activities in formal employment. Formal employment attracts greater social recognition and is the locus of true benefits of social life such as money, power, status freedom, opportunities for growth and self-worth (Ritzer, 2000). Adult men's social roles as "breadwinners" take most of them away from home and into the public sphere as economic migrants in towns or cities where infrastructures are developed. This means female households and children below 15 years of age are a common feature of rural areas (KDDP, 2001: 27). These effectively female households face major economic challenges when out-migrant husbands fail to remit or pay regular visits. In case of a separation, women must remain fidel to their husbands until they are reunited. Thus, incidences of extra-marital affairs to meet basic needs exist. A man caught having a sexual affair with another's wife pays, *malu*; this is a fine to the aggrieved husband aimed at punishing the transgressor(s). By contrast, marriage grants the man authority, mobility, and a right to domestic, emotional, and sexual services by the wife (Ritzer, 2000). In addition, he is entitled to extra-marital exploits and the pleasure of additional wives. These situations present a high risk of unwanted pregnancy that may end in abortion.

Women in Kenya constitute more than half the proportion of the poor with most living in the rural areas. Related to this are lack of exposure and knowledge of their rights and the resources potentially available to them (Omondi, 2003:4). With the exception of the Muslim culture that allows women to inherit property from their parents, Christians expect women will get married and share in their husband's property, condemning to poverty women who remain unmarried, or

have been divorced or are separated (MDDP, 2001).[49] Divorce rates, serial marriages and physical violence against women are high due to discrimination and cultural practices that disempower women and foster their dependence on men. This leaves a lot of women and children in precarious situations. On the bright side, the newly promulgated Constitution of Kenya (2010) creates space for women to inherit property from their parents. Hopefully, it will translate to women's reproductive empowerment. Poverty and abuse of alcohol or *mnazi* (palm wine, a traditional homebrew), particularly by men, are generally rampant in Kilifi as in elsewhere in Kenya. Living in poorer households and having an alcoholic partner increases women's risk of experiencing sexual abuse (Kimuna and Djamba, 2008).

Societal disapproval of contraceptive use particularly among young unmarried women and strong opposition to sex education in schools has meant unprotected sex practices are common. Sexual activity in early years poses great risk to the health of young women. Adolescents, regardless of marital status, often face difficulties in accessing contraception. Less than 20% of married women aged 15-19 years use modern methods of contraception compared to 49 per cent among married women aged 30-34 years (KNBS and ICF Macro, 2010). The unmet need for contraceptive for unmarried sexually active women in the poorest quintile in Mombasa is 68%. Women living in poor households are likely to engage in early sexual behaviour than their counterparts living in wealthier households (MLE, TUPANGE and KNBS. 2011). Regular use of contraception is not a simple matter during adolescence even in developed countries (Glasier et al., 2006). Little knowledge, little access to services, inability to negotiate contraceptive use, and less than average decision making power regarding reproductive health compared to older women, all result in low uptake and high rates of ineffective use of contraceptives.

Early marriage and pregnancy can lead to reduced educational opportunities for both mother and child leading to poverty. In the absence of contraceptive use, these factors lead to the likelihood of high fertility and unwanted pregnancy. Against the backdrop of chronic poverty, and with little partner support, an unwanted pregnancy triggers a chain of complex questions and circumstances for the woman to navigate.

[49] The recently promulgated Constitution of Kenya (2010) addresses this inequality. However, cultural practices take long to change.

Despite the near universal knowledge of contraceptives reported in consecutive surveys (CBS et al., 1998 and 2003; KNBS and ICF Macro, 2010) the practice remains correspondingly low. The prevalence of modern methods of contraception among married women (CPR) in the coastal region is estimated at 30% (KNBS and ICF Macro, 2010), the second lowest in the country.[50] Variations within the Coast Province show low contraceptive use in the Kilifi district, rated at less than 2% by the Kilifi District Development Plan (KDDP, 2001). The Mijikenda have for long resisted and stigmatised modern contraceptives although attitudes have changed considerably over time (Were and Mathu, 1980s).[51]

4.6 The Public Health System

At the time of the study, there were only three hospitals, six Health Centres (HCs), and some private clinics in Kilifi. Access to the Kilifi District Hospital (KDH) by women in the hinterland is a Herculean task. Access is compounded by the poor earth roads and infrequent and expensive road transport networks. Informal private health facilities exploit Kilifi and Mombasa women as they seize the opportunity to fill the unmet health care demand for services left by formal health facilities. In Mombasa, formal health facilities are insufficient too but easily accessible at an average distance of half a kilometer to a health centre because of the good road network, well supplied and relatively affordable public transport (MDDP, 2001). The Coast Provincial General Hospital (CPGH) located in the Island division of Mombasa serves as the provincial referral and training facility. Overcrowding is therefore a common feature. Besides the CPGH, there exist numerous private health clinics and hospitals of varying levels of formality and cost. Some of these offer post-abortion care services, pre-and post-natal care, including family planning counseling.

[50] The national prevalence for modern methods of contraception among married women is 39 per cent.
[51] Year unknown Government document available at the Mombasa district information and development centre (DIDC).

At the time of this study, the comprehensive post-abortion care (cPAC)[52] was only available at the provincial referral hospital (CPGH), the sub-district and district hospitals and a few HCs such as the Rabai Health Centre. The provincial hospital, despite its big distance from the women and high cost, is overburdened with caseloads of women in need of treatment for abortion complications because it is better resourced. On the other hand HCs which are closest to the majority of the women and offer near free services, are not only few but ill equipped to provide cPAC services. Generally, these public health facilities are insufficient to meet the increasing health care demand: there is a chronic shortage of medical staff and poor remuneration leading to overburdening, fatigue, and lack of motivation causing massive exodus of nurses to greener pastures. Thus, the cPAC strategy has not been sufficiently rolled out and its fullest potential in improving women's health has not been realized leading to the conclusion that multiple strategies are desirable.

Among challenges facing the health system is the historical exclusiveness of family planning services in the Maternal and Child Health/Family Planning (MCH/FP) Clinic. Consequently, the reproductive concerns of unmarried women have systematically been, not only ignored, but stigmatized. Given that public health facilities play the greatest role in dispensing contraceptives in the country (KNBS and ICF Macro, 2010; CBS et al., 2004) the existing traditional model has implications for marginalized members in communities at risk of unwanted pregnancy such as the single, separated, divorced and the widowed women.

Related to the above is that over 90% of deliveries in Kilifi take place at home with the assistance of traditional birth attendants[53] (TBAs) (National Coordinating Agency for Population & Development, 2001). TBAs consist of ethnomedically skilled women or simply adult women

[52]The cPAC was introduced in Kenya in 1996 post ICPD, Cairo (1994) to curb the high maternal mortality and morbidity arising from abortion-related complications. The cPAC strategy diversified delivery of family planning counselling services to the gynaecological wards to stem repeat abortions. Unfortunately, implementation of cPAC services face tremendous challenges mainly because the roll-out started from top to bottom rather than bottom to top in the hierarchy of health service delivery. It is therefore a tragedy that although cPAC is an essential package for health (KEPH), it lacks attention in the MOPHS strategic plan, and therefore in the Community Strategy.

[53] The MoH in the Kilifi district no longer recognizes TBAs who they consider unsafe birth attendants and responsible for the high infant deaths in the area. Women are encouraged to deliver in hospitals assisted by qualified medical midwives.

with embodied knowledge on birthing such as the grandmother, mother-in-law, or mother of the woman concerned.

4.7 Summary and Conclusion

In this chapter, I have shown how the complex and dynamic circumstances in Mombasa City and the Kilifi district settings contribute to the high risk of unwanted pregnancy and motivation for abortion. Low contraceptive usage; chronic poverty and food shortages particularly in the Kilifi district; poverty among the Kilifi women who together with their children constitute the largest proportion of the rural population; unprotected extra-marital sexual affairs due to non-remittance by the absent husband and marital instability; unstable unions of rural-urban male in-migrants with urban and peri-urban women; drug abuse; clandestine tourism prostitution including sexual exploitation of minors, are all situations that provide a high tendency for unwanted pregnancy and motivation for abortion-seeking. The analytical chapter that follows presents the data in the form of 49 case histories capturing the diverse experiences and both similar and sometimes unique circumstances of women in the study.

FIGURE 4-1: CHILD SEX TRADE RIFE AT THE COAST

16 NATIONAL NEWS
DAILY NATION
Friday December 18, 2009

COUNCIL REPORT

Child sex trade 'rife at Coast'

Between 10,000 and 15,000 girls involved in prostitution, say research findings

By KIBIWOTT KOROSS

Coast province is leading in child prostitution, research findings have shown.

According to the National Council for Children's Services, it is estimated that between 10,000 and 15,000 girls living at the Coast are involved in commercial sex work.

Child prostitution in the area is closely linked to the lucrative, and illegal, child-sex tourism.

The council's report says that most of the clients served by this industry, other than Kenyans, are Italians, Germans and Swiss.

Diani, Mombasa, Kilifi and Malindi beaches were noted as the major centres of sex tourism at the Coast.

Other urban areas, such as Nairobi and Kisumu, are also said to have high child commercial sexual activity, with poverty being the major contributing factor.

The council's report says that more than 30 per cent of all 12 to 18 year olds are involved in full-time commercial sex work.

For many people in the local community, the research findings say, having a daughter or a son in a relationship with a tourist, especially a foreigner, is seen as a source of wealth and status symbol.

An earlier report by the UN said that local communities' tolerance of prostitution involving children was helping entrench the practice in the area.

Beneficiaries

According to Unicef's 2006 "Report on the Extent and Effect of Sex Tourism and Sexual Exploitation of Children on the Kenyan Coast", family members, bar owners and their managers were the major beneficiaries of the trade.

The National Council for Children's Services report was presented to Gender, Children and Social Development minister Esther Murugi by Kenyatta University lecturer Barbara Koech on Wednesday.

For some, having a son or daughter in a relationship with a tourist is seen as a source of wealth

Figure 4-2: Map of Mombasa: showing health services and distribution of public Health Facilities

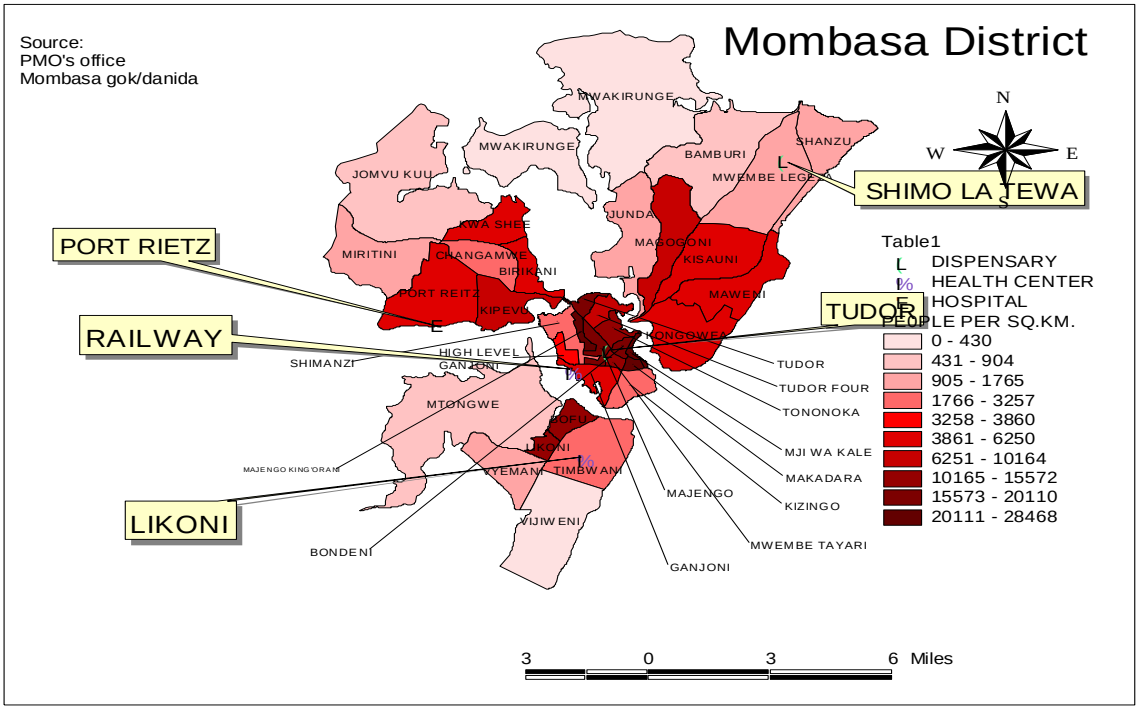
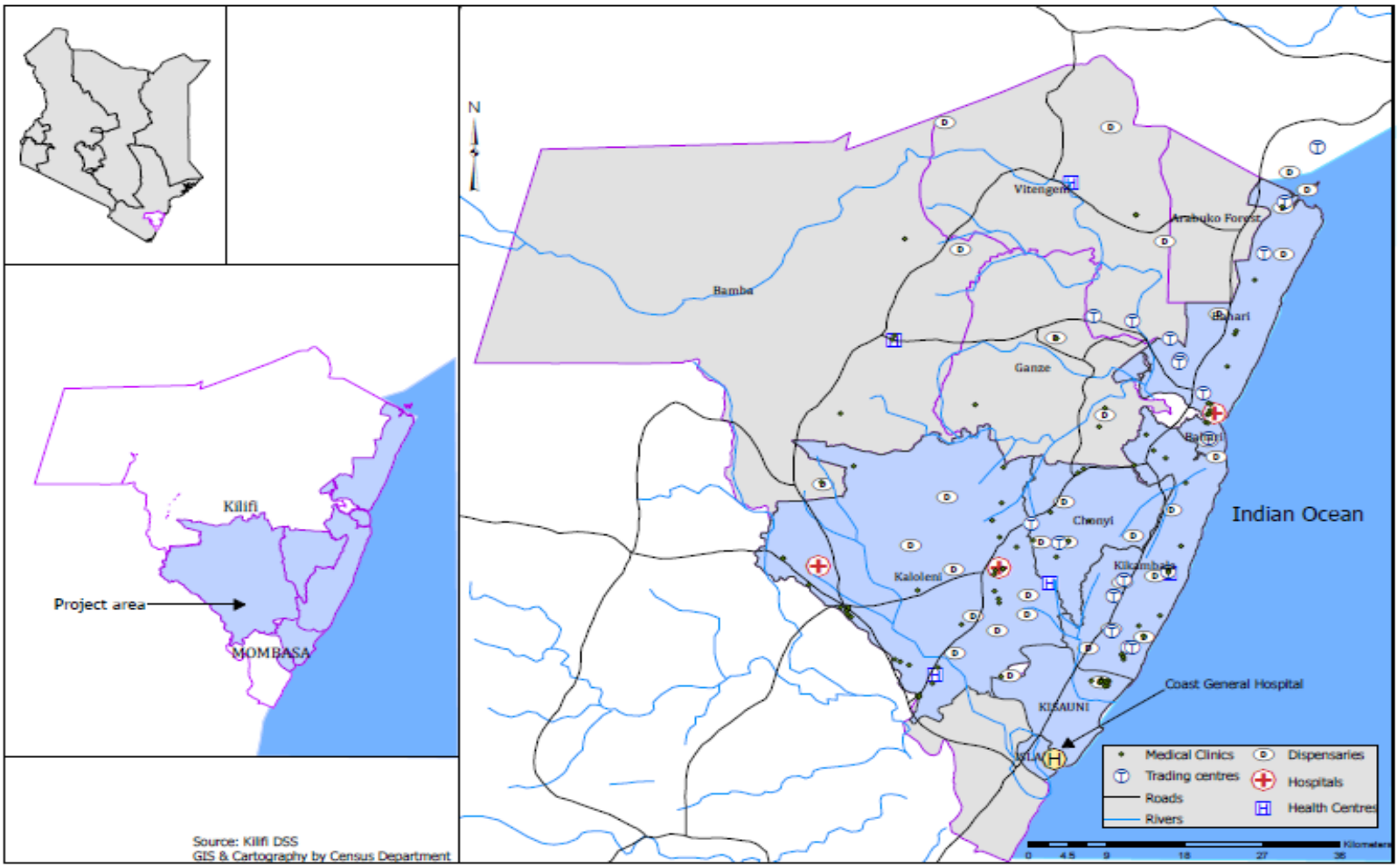


Figure 4-3: Map of Kilifi showing population density and distribution of public and private Health Facilities



CHAPTER FIVE

5.0PROFILES OF THE DIVERSE CONTEXTS IN WHICH WOMEN ABORT[54]

"*I had to*"

5.1 Introduction

This chapter discusses the first objective that reads: what social and legal issues motivate abortion-seeking behavior of women in the Mombasa and the Kilifi districts of Kenya? In this chapter I describe the complex forces impinging on the women and how they cope with the issues their pregnancy and abortion experiences involve. Understanding the decision-making process helps establish the context in which women opt to have abortions, hence clearing the common misconceived judgment that women/girls who abort a pregnancy are selfish (Petchesky, 1990). Indeed, the concluding argument in this chapter is that women do not abort motherhood but they do abort particular pregnancies.

The discussion is based on emergent themes and sub-themes drawn from data gathered through individual in-depth interviewing of the 49 women participants 33 of whom reside in Mombasa City and 16 who live in the Kilifi district. Three ideal types of relationships with men are identified: unstable, stable, and no relationship. Forty out of the 49 women studied are in unstable relationships including 34 who have 'never married,' 3, who were separated, 2 who were divorced and 1 widow. Of the remaining 9, 6 are in stable relationships while 3 are in no relationship with the men responsible for the pregnancy. Nearly half of the women (19) are below 20 years of age while the rest were above 20 years of age (17 were between 20-24 years and 13 were aged between 25-33 years). These women are of diverse socio-demographic

[54] Some data in this chapter is published in an article authored by myself. The abstract is in Appendix IV. Part of these findings were presented at the 2nd African Conference on Sexual Health and Rights, Nairobi 19-21 June 2006; and at the 8th Postgraduate Conference, Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal, October 28th, 2006

characteristics underscoring the fact that all women of reproductive age experience and abort unwanted or unintended pregnancy safely or unsafely.

The pseudonyms allocated to the women are coastal names common among the Mijikenda, the Swahili and up-country migrants. The titles "*Bibi"* (*Bi* in short form) an equivalent of Madam, and "*Binti"* are titles of respect used to address the married and 'never married' women respectively, in the coastal culture. The characteristics of the women at the time of the reported abortion are given preeminence in the analysis for better understanding of the situational motivators and consequent processes. For example, although at the time of interview *Binti* Maria is married, a mother, and in real life addressed as "*Bibi*", she was unmarried, in school and college at the time of her three abortions therefore titled "*Binti*". Incidentally, this further enhances the women's anonymity. Other attributes [bracketed] at the end of each quote found to influence the abortion decision and the abortion type[55] include women's marital status, ages and number of their children, education attainment, occupation, residence, and religion.

Patterns emerging in this analysis ascertain that the women in the urban and the rural areas struggle to control fertility in a conservative patriarchal and moral-ridden system that defines women's reproductive and sexual behaviours. Nevertheless, each woman's abortion experience is unique and is narrated in her own voice. The use of voices as "raw data" provides evidential support to the themes and sub-themes as well as echoes the experiences of other women with similar background characteristics and contexts thereby capturing the wide range of both similar and unique experiences of abortions of the women studied. The abortion experiences of the women, whether in the recent past or as long as seven years ago, is something the women say, "You can never forget".

[55]Safe abortion means successful completion of the procedure without any physical or reproductive damage by a medical practitioner trained in abortion care operating under sanitary conditions. Unsafe abortion is the reverse. However, an unsafe abortion may not result in complications or visible injuries; in such instances, women regard it "successful". "Clinics" are not licensed to operate by the MoH.

5.2 Abortion amongst Women in Unstable Relationships

The women in unstable relationships[56] include the 39 women: 29 of whom are 'never married' nulliparous, while the other 10 are mothers (5 'never married', 2 separated, 2 divorcees, and 1 widow). The bulk of abortions occur among these women. Cultural norms exist that regulate women's sexuality within and outside marital bonds. Marriage is one of the most important institutions fundamental for the construction of gender identity and sexuality. Sexuality is a cultural construct constituting the cornerstone of marriage (Silberschmidt, 1999). Expressions of sexuality outside marital relationships, often evidenced by pregnancy, are often considered illicit, are frequently unstable and may also be surreptitious. The women who engage in this type of sexual relations are regarded as "loose", and as "prostitutes" and others viewing them consider their motherhood to be shunned and stigmatized. Unsurprisingly, the bulk of the abortions, including repeat abortions, take place among women in unstable sexual relations, in particular, those who have never married. Factors intrinsic and extrinsic to the relationship influence the abortion decision. Most unstable relationships are characterized by male partners who offer no material support for the resultant pregnancy. Lack of material support is then an intrinsic factor that influences abortion. The fear that pregnancy will publicly expose the women's engagement in 'illicit' sex is an extrinsic factor that influences the abortion decision.

5.2.1 Abortion amongst the 'never married' women

Most abortions occur among the 'never married' 29 nulliparous and the 5 parous women studied. Unfortunately, at the time of first abortion the bulk of the 'never married' women are under 20 years and minors[57] in primary and secondary schools. "The first abortion I was still very young in Class Seven", is a recurrent narrative by the women who discontinue primary schooling. Most of the women are still dependents and live with both their parents while a few live with only one parent, a sibling or by their own. These women are religious and from Christian or Muslim

[56] see Appendix I: Characteristics of the 49 Women Participants, Tables 1a-e

[57] Persons under 18 years of age are considered minors by the Laws of Kenya and their enrolment in school is mandatory and free. Sexual intimacy with minors is a criminal offence.

family backgrounds some of which they describe as "strictly religious", "strict Catholic background", "strict Muslim family". The women struggle with conflicts between reality vis a vis religious and moral teachings by religious leaders and parents.

Stigma of untimely motherhood and evidence of 'illicit' sexual intimacy are the twain reasons that make abortion most frequent among the 'never married' women. These women experience extreme stigma, "Like myself, it is alright (to get pregnant) but for a girl to get pregnant, it is illegitimate and not accepted", stresses *Bi* Pendo, a married woman in the rural Kilifi. The community perceives women with premarital pregnancy to be disrespectful "this girl has no manners because she conceived while still at her parents' home", adds *Bi* Zena and Bi Anita both of the rural Kilifi. A woman pregnant while still in her parents' home is labeled a pariah in the community, a social misfit, "an outcast". She does not fit within the set social classification: "She is neither a married woman, nor a girl among her peer group", reiterates Nurse Zainab of the Mombasa city. She is considered an "idiot", "cursed" and "a shame", Nurse Zainab adds.

Furthermore, her chastity value diminishes and therefore, in the unlikely event that she gets married, the bride-price (*hando*) excludes the *mada*.[58] Social perceptions of a child born from this predicament are that they are misplaced and not belonging to any home, as the "father is not known", some people referring to such a child using the derogative term "bastard" (*mwanaharamu*), "illegitimate", or "unacceptable". In most societies, pregnancy outside marriage is a problem with the social repercussions of illegitimacy reaching out into the whole community (WHO, 2014; Izugbara et al., 2011; Ounjit, 2011; Bourne, 1971). Yet, for a variety of reasons, women often transgress the norms and secretly express their sexuality irregularly.

At the family level, untimely motherhood brings shame and potentially severs parent-daughter relations as engagement in prohibited sexual intimacy is viewed as a betrayal of parental trust. *Binti* Mercy agonized with thoughts that her religious parents will "kill" her "alive". Loss of parental bond is difficult to bear impelling her abortion decision: "Gosh No, I cannot (keep the pregnancy)!" *Binti* Mercy narrates,

[58]Money paid to mother of the bride (as goodwill for bringing up a virtuous woman) by the suitor/his family before taking her hand in marriage.

> "Then you know after that the trust, the closeness, you know I and my mum are very tight, all that goes away, because "this is my daughter but I can't trust her anymore", imagine!" [*Binti* Mercy: 1 safe abortion; 'never married'; nulliparous; pre-university; Kilifi Peri-urban]

While friendship with men is permitted, parental and societal expectations are that the 'never married' abstain from sex, "…not go to that extent of having sex", explains *Binti* Mercy. The women are "prepared to die" rather than for their parents to know that they had lost their sexual purity. Sexual controls are exerted more strictly on women who have never married because 'the chastity of a woman is the pride of her parents' (Kameri-Mbote, 2000-1). Social intolerance of premarital sexual intimacy explains why the 'never married' women react with denial, acute anxiety and trauma to pregnancy confirmation, while the married women seem less agitated. *Binti* Mercy's agony following two instances of unprotected, forbidden, sexual intercourse best exemplifies the state of the 'never married' women,

> "So I became keen on counting my days. The first day came and I missed my periods. I just gave it a week 'cause maybe it's taken longer than normal. But ….then I started experiencing these morning sickness and it's hell…I wake up and it's hell…and you start denial 'cause you don't want to believe it's true. So, I said, "OK, because I really don't want to say I am pregnant and I really don't want to believe it then I better go to a doctor." I came to a doctor out here in the neighbourhood. I didn't want to come to (name of family doctor). So then, [pause] it was confirmed and it was as if hell had really broken loose. Because when I imagine all the things that were going to happen now, no, it's too much." [*Binti* Mercy: 1 safe abortion; never married; nulliparous; pre-university; Kilifi Peri-urban]

The descriptive expressions such as: "hell had really broken loose", "denial", and others in the data such as "shocking", "surprising", then "filled with panic", "afraid", "worried", "I was caught", "by bad luck", "mistake", "the same mistake" and "I just saw problems…", anxiety

from the missed monthly menses, are telling of the unpreparedness and desperation at the implications. Unlike *Binti* Mercy who acknowledges unprotected sex, some women do not take responsibility but rather play the victim, "I was cheated"; "it could be that someone tricked you to sleep with him and you conceived, so you abort"; he "came with his sweet talk and I found myself giving in". It is apparent that these sexual activities are culturally 'illicit', take place unplanned and with power relations tilted in favour of the man. This seemingly passive disposition in matters of sexual relations is in congruence with the socialization of a "good girl", a reflection of low self-esteem and social status of the women. This theme of "mistake" and "getting involved with the wrong man" is reminiscent of Russian immigrants who viewed themselves as victims rather than actors unlike their Israeli counterparts who felt a sense of "personal failure in controlling fertility" (Remennick & Segal, 2001).

The stigma of untimely motherhood threatens women's career prospects and by implication their economic security and that of their families. The women recount their dreams and the punitive "things" they imagine would happen to shatter these dreams. Thus, the decisive conclusion, "no, it's too much!" reflects *Binti* Mercy,

> "Imagine I am just from school; I have not even done anything at least to show what I have been in school for. I want to go to college, I want to go to the university, I want to build a career for myself, and (raises voice) I really worked hard in secondary school to get to a university, I do not fit going down the drain". [*Binti* Mercy: 1 safe abortion; never married; nulliparous; pre-university student; Kilifi Peri-urban]

The women's considerations for abortion involve a complex interaction of layered and interlocked motivators. As *Binti* Mercy accurately states, motherhood and studentship are incompatible in Kenya; synonymous to "going down the drain" or the feeling described by other students in the study as, "the end of my world". Therefore, the abortion decision is a profound choice for future prospects, letting the unwanted pregnancy "go down the drain". Contemporary parents invest in their daughters' formal education so that they can compete with boys for employment in the public sphere, have economic independence and better living conditions for

themselves and their future children. However, some parents are reluctant to sponsor their daughters' schooling after they acquire the untimely role of mother. "Actually if my dad had found out, that would have been the end of my education and that is something I know for sure", *Binti* Mercy with certainty echoes the reasoning of many students. Ordinarily, fathers are feared the most because of their role as 'breadwinners' and sponsors of their children's education.

These women and their partners are unprepared for the responsibilities of parenthood. They are "young" and unprepared for the role of mother so childrearing becomes an added burden not just on themselves but impacts on their parents on whom they still depend. An emotional *Binti* Mercy impresses her reasoning on her college boyfriend, who wanted her to keep the pregnancy despite his unpreparedness for the 'breadwinner' role,

> "…and now what am I going to do with a baby this young (referring to her age- 18 years)…actually I don't even know if I can be able to carry it, you know it's like, now what am I going to do? Yeah so am giving my parents a burden, am giving myself a burden, so it's like… no I can't do it. It's too much (crying)." [*Binti* Mercy: 1 safe abortion; never married; nulliparous; pre-university; Kilifi Peri-urban]

Students in secondary school and college are more likely to have an abortion to postpone motherhood so that they can complete schooling and fulfill career aspirations. This is unlike their counterparts in primary school who desire marriage rather than continue with school after pregnancy. However, relationship issues, for example religious differences and no offer of support by partner frustrate these women's desire for marriage motivating abortion. Despite her intimacy with her Christian partner, *Binti* Salma aborted twice by unsafe means, due to religious discordance. "A Christian and a Muslim do not rhyme so it meant haa! I am aborting if I die all belongs to God". She explains that "if the home is very religious, it is difficult" unless the man converts to Islam. She feared her future child "would suffer religious identity and legitimacy".

On the contrary, after multiple abortions, the fear of threatened motherhood impels some Muslim women to defy religious restrictions and live with Christian partners. For example, after two

unsafe abortions of pregnancies by two serial partners who abandoned her, *Binti* Amina, a Muslim with incomplete primary education, got concerned that she was "getting late" for motherhood; her married sister already had two children. In her third pregnancy, although with a Christian partner, *Binti* Amina opted for a "come-we-stay"[59] relationship because he offered support in pregnancy. Early marriage is a common practice in Mombasa and the Kilifi district that partly explains the low level of maternal education in the region (GoK, 2001a; GoK, 2001b). Maternal education is a strong predictor of maternal and child health as is maternal age.

Moreover, although some women with primary education desire marriage, they opt to abort because their partners offer no support in pregnancy. Additionally, women who are the sole breadwinner to their siblings fear the economic burden of caring for a child unsupported by their partners will increase their (siblings) vulnerability. Similarly, all women with at least one child and are in unstable relationships are likely to abort repeat pregnancies if marriage is unlikely or the men offer no material support. For the few of them who are in formal employment the sole burden of an additional child makes it untenable given their meager salary. Most of the women rely on the support of their family, that is, parents, sisters, or brothers in caring for their existing child because they have little or no income of their own. Some already struggle financially to send remittances upcountry for the support of children they left behind under the care of their parents or married sisters. "Another mistake" means they take for granted their (families') forgiveness of the "first mistake". Their families would regard them "foolish" and "irresponsible" getting an additional child without partners' support or stable relationships. Hence, the women abort to avoid a stressful motherhood, says *Binti* Chao,

> "So now you know … I still stay with my mother up till this moment. So if I conceive another pregnancy, will they not see like it is a game/joke now; that I can give birth again and have the baby brought up by them again? So I did it." [*Binti* Chao: 1 unsafe abortion; never married; 1 child; complete secondary education; Mombasa City]

[59]A terminology used in Kenya to refer to an informal union between a man and a woman by mutual agreement and functions almost like a marital relationship but lacks cultural legitimacy. This emerging phenomenon is commonly found in urban areas. Being an unstable relationship, some do break up while others get formalised in the future.

Repeat abortions are common sometimes of pregnancy by the same or a different man but the intertwined reasons change little. For example, *Binti* Amina aborted twice pregnancies of different men after false promises of marriage each time. It is instructive that the women care for motherhood but will abort if a relationship is unviable at the time. On the contrary, despite a viable relationship, untimely motherhood motivates abortion among women of secondary school and beyond, particularly upcountry migrants. *Binti* Francie aborted thrice with the reluctant support of her fiancé of eight years, and her current husband because of the desire to conceal her engagement in 'illicit' sex. She was a secondary school student in two of her abortions, while her third abortion she wanted to fulfill her career aspirations. Her other reasons are dreams of a 'white gown' wedding before entering motherhood in order to be exemplary to younger siblings and as a youth leader, to the community church. Some women abort repeatedly because of parental disapproval of partner due to social class differences; unprepared to take on the sole burden of child care; already struggling to support a child alone. These women desire to bring up their future child in an atmosphere of social acceptance, with a father 'breadwinner', and in their own place they can call home.

Diverse families vary in their treatment of pregnant daughters or sisters, with fathers and brothers being the main decision makers because they own the family land or are heirs respectively. On the one hand, some progressive families extend support so that their daughters/sisters can complete school. Nonetheless, a premarital child continues to live with the grandparents if the mother marries a different man in the future. In this case, the women are less likely to have another unwanted childbearing until marriage for fear of family wrath as discussed above. In an atmosphere of family acceptance and material support their existing premarital children are less likely to be vulnerable.

On the other hand, some families in the rural Kilifi banish from home their primary school-going pregnant daughters, who in turn migrate to the Kilifi town to fend for themselves and their child. The parents abandon these girls to avoid public shame of their daughters' pregnancy with no prospect of marriage. This rejection makes the girls vulnerable to sexual exploitation and the

vicious cycle of poverty, unwanted pregnancy and abortion. Hence, "that is why there are many young girls roaming around in Kilifi town", a common phenomenon epitomized by *Binti* Halima.

At the tender age of 14 years, and with five years of primary school (Standard Five), *Binti* Halima was banished from her rural home because her parents were unable to bear the shame and the economic burden of her untimely motherhood. The man responsible for the pregnancy, an employee of the then Ministry of Education, Science and Technology in Kilifi district abandoned her. *Binti* Halima, a child mother, migrated to the Kilifi peri-urban where she lived alone. Desperate to support herself and baby, she struggled with odd jobs, hard labour in construction sites, slashing grass and so on; she was vulnerable to sexual abuse by men, stigmatized as a "prostitute", and "loose". A girl with a premarital child is considered to be sexually available for all men because she is no longer "a virgin". It is in this context that the now 39 year-old *Binti* Halima started sex work and has had multiple pregnancies from different men, four sons and five abortions, both unsafe and safe. Her story depicts the socioeconomic disempowerment of women from puberty through to the exit of their reproductive cycle by male domination and abuse. Their children are likely to be similarly vulnerable perpetuating the cycle of poverty and abortion.

5.2.2 Abortion amongst the separated women

The second type of women in unstable relationships is the separated. Like the 'never married', stigma of pregnancy "not from your husband", referred to as *haramu* meaning, illegitimate motivate abortion to cover evidence of 'illicit' sexual relations. The women refer to such pregnancy as "silly pregnancies" because they understand the cultural prohibitions. Unlike the 'never married' women, the separated women expect the resultant pregnancy from unprotected sexual intercourse so it is not "shocking", but do not accept maintaining the pregnancy because of the implied problems; *Bi* Neema explains,

> "…there is nothing like unwanted pregnancy. Every pregnancy is wanted but sometimes you do not accept it because of some problems, for example, with us who have no husbands." [*Bi* Neema: separated; 8 children; 1 unsafe abortion; complete secondary education; Kilifi Rural]

According to *Bi* Neema, a mother of eight children, and still in her early thirties, separations in the hinterland are on the rise as men abandon their wives for other women. The men's promiscuity results in denying conjugal rights to their wives and men's abdication of their 'breadwinner' role, which is contrary to the norms. In this context of early marriages, women are still "young" at separation, increasing the likelihood of extramarital heterosexual intimacy, consequent unwanted pregnancy and increased demand for abortion. To address this emerging phenomenon that challenges traditional norms, *Bi* Neema advocates for abortion, she explains,

> "Let (allow) the people terminate because nowadays us women are deserted by our husbands so often. If he gets another woman, he will chase you. If another woman is brought into the house, you will not be able to stay there unless you are old. For somebody like me who is still young, I cannot stay because I still have an urge and who will take it away? I will have to look for somebody from outside." [*Bi* Neema: separated; 8 children; 1 unsafe abortion; complete secondary education; Kilifi Rural]

For these women, abortion is necessary because they are culturally not divorced "I haven't been paid back any money".[60] *Bi* Neema means that her estranged husband has not yet returned her bride-price to her natal home so in this context invokes her cultural values that she is still married to him. Divorce is alien to the Chonyi and the Giriama (GoK 1980s:40). In traditionally patriarchal societies, women are socialized to suppress their sexual desires while men are encouraged to have sexual exploits, indeed multiple, regardless of marital status (Preston-Whyte, 2003; 1992; Izugbara et al., 2011; Ounjit, 2011).

During the separation period, the women return to their natal homes and sometimes bear the material burden of child care. Some rely mainly on subsistence farming on land temporarily apportioned to them by the male relations, father or brothers so that they can feed themselves and their children and also pay their school tuition fees. In this struggle, these women also engage in

[60]In traditional Mijikenda practice, also common in other cultural communities in Kenya, the divorce process involves repayment of dowry to the husband/his family by the woman's family. This is often a rare event.

diverse income generating activities that include small businesses, casual labour, and sexual affairs with married men in exchange for basic material need. Women's social position puts them in perpetual dependence on men. Their strategies of survival and resistance place them in cultural conflict and contradiction as they try to balance punishable extramarital affairs. *Bi* Neema's case typifies gender power relations and the often sad reality of women's destitution and desperation, pronounced during a separation. She narrates her difficult situation,

> "I had to (abort). Look at me for example, if I had kept the pregnancy I would be counting nine children[61] now and their father is not bothered about their education. Truthfully speaking, I cannot adequately provide food for my children because I am unemployed and dependent solely on farming which depends on the season. I myself have to do casual work so that I get food, how will I feed an extra mouth?" [*Bi* Neema: 1 unsafe abortion; separated; 8 children; complete secondary education; Kilifi Rural;]

Despite promises by her 'illicit' partner that he will support the child if it is a boy[62]; the risk of having to "feed an extra mouth" was untenable to *Bi* Neema. Since the separation, her estranged husband and father of her seven children (six sons, one daughter) is least concerned about "the most important things in a child's life", that is, education and food. Schooling is valued by Kenyan families as a path out of poverty. Food insecurity in the Kilifi district is a phenomenal problem that impacts on women the most, and is compounded by the instability of the family institution. Supporting *Bi* Neema's account, the Area Chief of the rural Kilifi laments that many men in the area are idlers (*wazembe*), and spend their hours drinking the popular *mnazi*, a local brew tapped from the coconut palm tree. Many are reckless and abandon their economic roles in the household. In her writings, Silberschmidt (2005: 191) observes that 'declining rural opportunities have put increasing strains on social roles and obligations' eroding men's ability to be breadwinners'. That men resort to alcoholism can be viewed as a 'withdrawal' strategy from

[61]*Bi* Neema has a pre-marital child born while she was in secondary school (Form Two). Her family, though traditional, is progressive. Her brothers agreed to support her complete secondary school while they care for the baby. After school she married a different man and left her son with her brothers. At the time of interview, her son was in secondary school (Form Two).

[62]Cultural preference for sons is evident. The 'illicit' partner (married man) wanted a boy from *Bi* Neema who has seven sons while his wife only bore him daughters.

their household responsibilities (Silberschmidt, 2005). This behaviour is likely to result in increasing rates of abuse, violence, and subsequent breakdown in family stability, leading to increase in abortions as *Bi* Neema argues.

According to observations by the Area Chief of the rural Kilifi, given that polygamy is an acceptable cultural practice, it is usual for men to have multiple relationships with women, and live off them as they are assured of a good daily meal while women compete for their affection, even when their economic input is negligible. This phenomenon of subverted social roles by women and men is evident in the Kilifi peri-urban area also where some men live with and are dependent on female sex workers for their survival (refer to *Bi* Fatma, the widow, below).

Abortion provides an option for women to resolve the cultural dilemma they face to sustain community harmony. A separated woman lives at her natal home until the time her husband demands her return to the marital home. She is "tied" there by her children, *Bi* Neema says, "I have children there", so it "is not over between him and me"; "Anytime he comes and says, 'I want my wife' I will have to go back…but if he comes finds me pregnant will he accept me?" At the time of the interview, it was nearly a year since her separation. It is for this reason that abortion is impelling, she continues to narrate,

> "Now I was burning up in my brain (thinking hard in dilemma) for that reason. So I had to terminate the pregnancy; if he comes for me fine, he does not I know am very clean. I have nothing. So I am feeling very all right, no problem." [*Bi* Neema: 1 unsafe abortion; separated; 8 children; complete secondary education; Kilifi Rural]

Abortion gives the women "peace of mind"; they understand and respect their culture. Cultural controls in a patriarchal society demand moral innocence by women during separation; they must remain "very clean". In traditionally patriarchal societies, moral purity is required of women while the opposite is expected of men (Preston-Whyte, 2003; 1992). The women have agency in abortion; they take control of their situation to retain their social position. In her observation of

Gusii women and men in Kenya Silberschmidt (1999) concluded that women seem to be able to draw on traditional cultural norms and values much more than men.

Bi Neema continues to unravel other intertwined cultural implications layered in her motivation to abort. In a traditional patriarchal system, land belongs to men and is passed on to the male generation, a position that is fundamentally changed in the new constitutional dispensation (Constitution of Kenya, 2010). Therefore, a woman belongs where her sons have entitlement to land. A child born from extramarital sexual relations, particularly a son, faces identity issues as "culturally, that baby would not belong to that homestead" (referring to her natal home). "There would be conflict all the time" with her brothers and their sons who are the rightful heirs. In fact, "the whole community will be against you and regard you a stupid woman", reasoned *Bi* Neema. Going against the community is not an easy thing for an individual to do. Payment of a fine, *malu*,[63] is due to the husband, by the offending man, when a wife is known to have extramarital sexual intimacy. *Bi* Neema explains that, "Nowadays, the money paid as *malu* is a lot, from twenty thousand (KES 20,000) and above. Sometimes it can be even more than dowry." After the payment of this fine, it is the man's prerogative "whether to continue staying with his wife or send her back to her home." These social values and cultural ideologies exemplify male power in controlling women's sexual behaviour.

5.2.3 Abortion amongst the divorcees

Common to women in unstable relations, stigma of pregnancy resulting from 'illicit' sexual relationship impels women to abort to avoid bringing shame to their parents and veto by the religious community. "I am sorry to say but this one had to go", says Nurse Zainab, of her second pregnancy by her estranged husband. Nurse Zainab, a Muslim in her early thirties is a qualified nurse in formal employment in the City. She and her husband "had no quarrel" but divorced after her in-laws' interfered with their marriage wanting their son to marry a woman of their choice. The mother of one child at the time of abortion laughs as she says that "we

[63] *Malu* is the fine paid by a man found guilty of having an affair with another man's wife. The aggrieved husband declares an amount of money he wants for appeasement. The accused man has to pay the fine to avoid further intervention by elders and the Area Chief.

continued to have occasional" sexual intimacy in secrecy. She aborted the two-week pregnancy to conceal her engagement in an 'illicit' sexual intimacy, she explains,

> "He was not my husband at that time. Although we had been married, we had separated at the time, so it was not something which could be allowed and my parents are very harsh. OK it was a bit shameful to me because where could I have gotten it (read pregnancy) from at that time (laughter). What I feared was actually the shame, being accepted by the community….. the fact that I was going to be ousted out of that community to me was kind of to be a very bad experience. So it had to (go)." [Nurse Zainab: 1 safe abortion; separated; 1 child; tertiary education; Mombasa City]

Cultural control of women's sexual behavior during a divorce induces fear of being labeled promiscuous and ostracized by the family and the Muslim community. After one and a half years, Nurse Zainab remarried her estranged husband and delivered their second child in an acceptable relationship. Nurse Zainab's case uniquely demonstrates the social and cultural (religious) controls of a woman's reproductive behaviour and is instructive that the social circumstance within which pregnancy is conceived greatly influences maternal acceptance.

5.2.4 Abortion amongst the widows

Like the other parous women in unstable relations discussed above, the widows abort because of relationship issues, in particular, lack of male partners support in pregnancy**.** *Bi* Fatma, a Muslim widow 24 years old and living in the Kilifi peri-urban off the Mombasa-Malindi highway married at 17 years after she conceived while in secondary school (Form Two). Her husband, the breadwinner, died leaving her with two children, 11 and 8 years old. She re-organized her family life in order to cope with the economic challenges of being the sole breadwinner for the first time. She resettled her children to live with her mother in the rural Kilifi. A year later, she returned to the peri-urban alone to work as a caretaker of an *Mzungu's*[64] house and sends remittances to her mother for the support of the family. Bi Fatma's entry into sex work, an

[64]*Mzungu* is the Ki-Swahili colloquial for a "white man" but the original meaning is an English person. The *Mzungu*, a white tourist, owned a holiday house by the North beach in Kilifi where he lived seasonally and employed a caretaker to mind the house for most of the year when he was away. This is a common practice by tourists.

'illicit' trade and with social disrepute was in a desperate attempt for a convenient means of livelihood to supplement her income. Her case illustrates the tragedy of women's economic dependence on men which leaves women destitute and vulnerable to the intrigues of sex work in their transitioned phase of widowhood. It is in this context that *Bi* Fatma aborted twice by unsafe means in serial relationships each time with false promises of marriage, she narrates,

> "Those other two pregnancies when I got them to be honest, I had to terminate. I just saw I had too many problems and I did not expect to get such a thing so it was like bad luck. You get a friend and you move on well but when you get that thing and explain to him he refuses and says "aaagh! I cannot be responsible for it" (makes gestures with hands). Therefore, when I reason out that I am the mother and father of my children because the father of my children died..." [*Bi* Fatma: 2 unsafe abortions; widow; 2 children; incomplete secondary education; Kilifi Peri-urban]

Paradoxically, it is common practice for sex workers to live with a man as husband, subvert roles by providing for the male partners from their sex work earnings, perhaps to fulfill societal normalcy while covering the stigma associated with the trade. "In the evening, I dress up in my nice clothes I go out while I live him sleeping", says *Bi* Fatma. These women are trapped in the web of high risk behavior as the male partners they sometimes refer to as 'husband' refuse to use condoms because "I am like his wife". Some of the women have a child or more with their male partners in a desperate attempt to cement their relationship or secure a male provider locally known as a *msimamizi*.[65] Often, these male partners show no commitment to family responsibility and a long-term relationship which the women desire. This increases their vulnerability to a vicious cycle of poverty, sexual exploitation, unwanted childbearing, and abortion, in attempts to shape their lives, and as a means to overcome the tensions and contradictions in their lives.

[65]*Msimamizi* is a (male) partner who provides material and emotional support to meet a woman's needs irrespective of marital bonds.

5.3 Abortion amongst Women in Stable Relationships

The seven women in stable relationships[66] are married. Dominant social norms and values dictate marriage as a precondition for motherhood. It is in marriage that sexual intimacy is socially approved and motherhood exalted. Childbearing is associated with, indeed synonymous to wifehood. Thus, pregnancy for the married women is an expected norm. Indeed, hairdressers use marital status as the criteria in "counselling" women who seek their advice on abortion: "if she has a husband, we tell her to keep it, if not, we tell her to abort". In this context, hair salons are meeting points where many women seeking services freely share information on relationship and personal issues that commonly affect them and offer solutions. Some hairdressers are 'never married' mothers, some have previously aborted, have a wealth of information and solutions given their interactions with diverse clients.

Thus, induced abortion in marriage is an unexpected choice. Nonetheless, women in stable relations regardless of their demographic, cultural and socioeconomic backgrounds experience unwanted pregnancy that results in abortion. These women are mothers, Christians, Muslims and of Traditional religion. The women live in the rural, peri-urban and the city. Their ages range between nineteen and thirty-three years. Extrinsic factors influence their abortion decision. These include deteriorating economic opportunities and consequent health implications for the existing baby. The experiences of these married women are particularly important in dispelling the myth that childbearing is always desired by married couples, more so those living in the rural areas.

The married women's obstetric histories demonstrate their struggles with unplanned pregnancy. Although *Bi* Rehema's third pregnancy followed contraceptive failure, this is not her reason for abortion. "My baby was still very young", is the popular echo among the women for taking the abortion decision. On further probing, *Bi* Rehema reveals her reason for abortion "I had to in order to save my child from dying". Her existing second born child who was eight months old and crawling, "…was sick, vomiting and so weak". She had taken him to hospital with no success; which, from her ethno-knowledge and lived experience, is a sign that she could be pregnant again.

[66] see Appendix I: Characteristics of the 49 Women Participants, Table 2.

> "I did not know I was pregnant at that time because I had started using 'sindano'/injection seven months after the birth of my last child. I stayed for three months without periods but I was not worried because the doctor had told me the 'sindano' had such an effect. I went for a second three-month injection immediately the first one expired. After that I felt like I was pregnant, I started feeling the changes and a hard thing here in my stomach. I went to the hospital (Kilifi District Hospital) for check-up and they told me that I was pregnant. I asked, "How can I be pregnant and I was using the 'sindano'?" the nurse told me that "the injection did not suit you. There is also another woman who came here and got 'sindano' and later conceived just like you." I do not even know how old the pregnancy was, the staff at the hospital did not tell me anything." [*Bi* Rehema: 1 unsafe abortion; married; 2 children; complete secondary education; Kilifi Rural]

The child's "deteriorating health" and a feeling of "hardening of the stomach" are among symptoms that prompt mothers to suspect pregnancy. These are useful indicators for women in remote and poor resource settings where public health facilities and family planning services are scarce. After being confirmed positive for her third pregnancy at the Kilifi District Hospital (KDH), she knew she could not carry another pregnancy too soon due to difficult economic circumstances resulting from her husband's retrenchment from employment "I had learnt a lesson with my firstborn; he was barely eight months old and in the same condition", she explains. The baby in the womb would kill the existing child who is still eight or nine months old, and not started standing or walking independently. Demographic and health surveys have repeatedly demonstrated that children born within less than 24 months of the preceding birth have increased risk of mortality (KNBS and ICF Macro, 2010). In India, abortion of pregnancy that comes when the existing baby is still young is a common reason for abortion among young married adolescents (Ganatra and Hirve, 2002; Ramachandar and Pelto, 2007; Puri et al., 2005).

Interlinked with the above is the health concern for the mother. Pregnancy has adverse effect on some women's health. *Bi* Rehema's other concerns is that, "when I'm pregnant I become

helpless who will take care of me?" Pregnancy compromises women's capacity to care for other children who still "needed much care" and the entire family. Additionally, there is scientific evidence that 'pregnancy is the most dangerous health event for women in sub-Saharan Africa' (Hubacher, 2008: 73; Berer, 2007). Saving the life of an existing child after another pregnancy comes 'too soon' is financially costly from the couple's experience. *Bi* Rehema's husband was in formal employment in the Mombasa City at the time so he could afford to engage his extended family in the care of their existing child. This involves supplying material provisions for two families. The risk to child survival of close spacing is significantly reduced when a household is wealthy (KNBS and ICF Macro, 2010). "Life these days is not as it used to be,...", *Bi* Rehema echoes her husband who expresses the same view in a separate interview,

> "Life these days is not as used to be, the economy has changed for the worst. We thought we should do that (abort) so that we may have enough time to prepare for another baby when we really need it. Right now, I am jobless and I do not know when I can be recalled to work. It is not good to bring children into this world for them to suffer later." [*Bi* Rehema's husband]

The private and public sectors were undertaking retrenchment at the time of data collection in the year 2005, a countrywide economic strategy to reduce the number of employees for increased efficiency. This fate affected many families in Kenya. The capacity of the "breadwinner" to provide is a critical determinant of the abortion decision. Also, formal employment, as opposed to subsistence farming, enhances the capacity of the "breadwinner" to provide for his family and overcome the "ever soaring cost of living" that women decry. When this capacity is threatened or diminishes, abortion of an unintended pregnancy is likely to occur because couples worry about the health and future of their unborn and existing children. Families, particularly in the rural area of Kilifi, are becoming increasingly, indeed rapidly poor (KDDP, 2001). Families cannot afford to have a child without careful planning and preparation as they did previously. Given inaccessibility to family planning methods in the rural area or method failure in some instances, abortion is a decision couples must take at particular times so that they can best provide for their existing children as responsible parents.

Researchers have observed that fertility decline among rural families in Kenya is partly due to concerns about rising economic costs of bringing up children (Robinson & Harbison, 2006; Robinson, 1992). Macro-economic forces propel abortion decisions at the micro-level of the family. Even when the married women live in the urban area and are in informal employment such as hairdressers (salon) the high cost of living impels them to abort to limit family size. Nineteen year old Bi Nadia with incomplete primary education says, "Three children is bad news these days, there is no money, and three are very many". Although she lives with the father of her second child, both her children live with her parents in the rural area which could be an indicator of her husbands' inability to provide material care. Thus, women in stable relationships abort in their desire to limit fertility as part of responsible motherhood. In the absence of contraceptive use or where contraceptives fail, some women rely on abortion to resolve unwanted pregnancy (Sedgh et al., 2007)

5.4 Abortion among women in no relationship- the raped

Some women abort pregnancies that are the result of forced sex by men with whom they had no intimate relationship.[67] Violent gang-rape by strangers and rape by male acquaintances after taking drugged drinks unsuspectingly are common. The punitive abortion law condemns the women to live with the consequences of the offense for the rest of her life. Rape pregnancy stirs legitimacy issues, stigma, and punishment to the woman similar to those of pre- and extra-marital pregnancy discussed earlier in this Chapter. Bi Wendi's first pregnancy after marriage was the result of rape by a family friend while her husband was abroad, she vividly describes,

> "It is a pregnancy that you do not intend to carry, to me that was unwanted because I was drugged. I did not know how I left that table; ….I did not know where I was…I was just feeling pains. It was forced (sex). It was horrible; it was a very painful experience. I would not really want to carry pregnancy of someone I had never loved; also I did not want may be not to love this baby. And then it was

[67] see Appendix I: Characteristics of the 49 Women Participants, Table 3.

> something shameful." [*Bi* Wendi: 1 safe abortion; married; nulliparous; tertiary education; Mombasa City].

The women describe the rape experience as "horrible", "disgusts", "very painful", they are "full of hate", shame, indignity, trauma and did not want to tell anyone. Rape in itself is loaded with stigma and self-blame. The post rape silence is due to societal blame of female rape victims. Consequently, the women fail to seek post exposure prophylaxis (PEP) or perhaps women may lack awareness of the services. It is "after some months when I missed my periods..." that the women finally seek medical services with double trauma. That women fear pregnancy, more than they do HIV and AIDS among other sexually transmitted infections is well demonstrated by *Bi* Wendi's narrative,

> "Then the worst happened, I was confirmed pregnant. I cried but I had no alternative, I had to terminate it. I had to take the risk (of abortion). I did not want to discuss it with anyone (sighed looking disturbed)." [*Bi* Wendi: 1 safe abortion; married; nulliparous; tertiary education; Mombasa City]

Once again, the women fear pregnancy because it presents sooner than AIDS as public evidence of their indulgence in forbidden sexual intimacy. Abortion shields women from societal judgment on their moral decency. Most cases of rape in Kenya go unreported, hence the problem remains invisible. The women consider it unthinkable to carry the pregnancy of a man they never loved, fear projecting hatred on the unborn baby, and for the married women, the potential of dissolving marriage. All study informants are in consensus that rape pregnancy must be aborted.

Conversely, there are instances of coerced sex in dating relationships. *Binti* Maria's first pregnancy was the result of coerced sex by a man she loved, her current husband. Reflecting on her first abortion, *Binti* Maria states, "I can remember I was telling him no, no but he forced me; therefore, to me that was unwanted". However, underlying reasons reveal multiple layers of conflicts such as the fact that she still lives in her parents' home, her family's high academic expectations, and her strict (Roman) Catholic background which would mean possible ostracization by her family. This underscores the fact that pregnancy is not aborted simply

because it is unintended or unwanted. Nonetheless, *Binti* Maria's case is indicative of the fact that the first pregnancy of many women could be the result of coerced sex by boyfriends, therefore unwanted. There is sufficient evidence that non-consensual sexual experiences are common among young Kenyan men and women (CBS et al., 2004; Erulkar, 2004; Njue et al., 2006). This brings in the broader view of sexual assault punishable by the newly enacted Sexual Offences Act No. 3 of 2006 (Laws of Kenya, 2007). The behavior has implications for sustained abortions and unwanted childbearing.

5.5 Summary and Conclusions

This Chapter concludes that social rather than legal issues motivate abortion-seeking behavior of women in the Mombasa and the Kilifi districts of Kenya. The women do not abort motherhood, but they do abort particular pregnancies. Hence, while women from diverse backgrounds abort, the bulk of abortions, including repeat abortions which are common, take place among women in unstable sexual relationships, in particular, those who have never married; the nulliparous, those who already have borne children, sex workers; hairdressers; and those below age twenty; students, out-of school women; Christians, Muslims and Traditionalists. The types of sexual relationships women have with men motivate abortion. The abortion motivators are intricate intertwined layers of extrinsic and intrinsic factors to the relationship. Abortion of unintended pregnancy resulting from sexual violence is also common place. While gender power is tilted in favour of men, women's agency in relation to patriarchy is clearly demonstrated in the way they invoke traditional values and norms, decide on abortion regardless of their partner's perceptions and desires, in order to shape their lives, and as a means to overcome the tensions and contradictions in their lives.

Women abort to avoid a difficult motherhood that is likely to compromise the quality of care they envisage for their potential and existing children. This includes ensuring the best nurturing environment, material provisions, paternal and religious identity, social legitimacy. additionally, students abort to make it easier to continue with schooling, secure their future economic prospects, which will in turn impact on the quality of life they want for their potential children;

they want to have an enjoyable motherhood and love their potential children; they abort because they want to protect motherhood; to have a dignified and worthy motherhood. All the above lead to the impelling three-word refrain by all the women, “I had to”. In the next chapter, I analyze how these women access abortion services.

CHAPTER SIX

6.0 ROUTE TO INDUCED ABORTION ACCESS[68]

6.1 Introduction

The data analysed in this chapter are used to respond to the second research question: How do the social and legal issues impinge on abortion-related decision making by women in the Mombasa City and Kilifi district? The chapter attempts to create an understanding of who makes the decision to abort and the difficult nature of the decision; the context within which the women access abortion care and the factors that influence access. Quotes drawn from diverse women participants enrich, broaden or bring in new dimensions or deviations to underscore the complexities The Figure 6-1 found at the end of this chapter captures the findings diagrammatically for easy conceptualization.

6.2 The Decision

6.2.1 Personal versus Consultative Decision

The type of relationships women have with men at the time of their pregnancy influences who makes the abortion decision. For the women in unstable relationships ('never married', separated, divorced, widowed) the abortion decision is individual, "personal", whether or not they inform their partners about the pregnancy. It is "my choice, my decision", is the refrain by these women because pregnancy impacts on them (and their families) the most. In most instances, the 'never married' women do not discuss the pregnancy with the men responsible

[68]Part of these findings were disseminated at the Population Association of Southern Africa conference held in North-West University, Mafikeng, South Africa, 25-28 September, 2007 and at the 2nd African Conference on Sexual Health and Rights, Nairobi 19-21 June 2006

because they anticipate no offer of support. Only in a few instances are the men responsible supportive of the pregnancy. Nonetheless, the women's decision prevails. Despite a differing view by her college boyfriend, *Binti* Mercy made an independent decision, projecting an assertive, pragmatic reasoning in her argument,

> "'…you are the one who is stupid, what do you expect me to do with a baby this young (referring to her age) and you can't even feed it yourself… No I can't do that!' So he had no say actually, it was my choice, it was my decision; he just had to go by my decision." [*Binti* Mercy: never married; nulliparous; 1 safe abortion; Kilifi Peri-urban]

Unlike *Binti* Mercy's partner who is a college student and a dependent, sometimes partners are in formal employment and capable of supporting a family. *Binti* Francie's fiance' and current husband supported and financed the 3 abortions despite his differing view. Without marital relations, men have limited reproductive power over the women.

The married women make a consultative decision for abortion. After *Bi* Rehema tested positive for pregnancy at the Kilifi district hospital, they decided to abort, she says "When I came and consulted with my husband we decided to terminate". Indeed, the husband has the "final decision" because he is the "breadwinner", and finances health care for the family. "He is the one who knows whether I give birth or I threaten/risk my life." In marriage, most husbands make health decisions because they often have economic and cultural superiority. This scenario is contrary to public discourse that blames women for abortion.

In rare cases the married women, mainly residents of urban and peri-urban, make an independent decision to abort. These women express fear that their husbands will have a different opinion, tell them "to keep the pregnancy". During the field work, there were also repeated reports from diverse study participants in the urban and peri-urban about the murder in Mombasa City of a medical doctor. The murder is said to have been performed by thugs sent by an irate husband after his wife aborted without his knowledge. There is need for further investigation on abortion decision making among married women residing in the urban and peri-urban areas of the study

sites. Such a study would also pay attention to the fluid marital relations and subverted gender roles in the urban area more than in the rural area which this study observed.

Overall, all the women are of the view that women in unstable relations must take personal responsibility for the decision to abort because pregnancy affects them the most. Additionally, the women argue that abortion in Kenya is a suicidal decision, often associated with complications that include death; hence the decision must be personal *Bi* Pendo[69] says, "you will be threatening your own life: you can die or only the baby dies. Therefore, you have to decide for yourself and say, 'Whatever happens, let it be'" or like other women submit, '…if I die all belongs to God". Unlike the parous women, the 'never married' nulliparous women agonise and delay making the abortion decision after confirmation of pregnancy.

6.2.2 Difficult Decision

The abortion decision is difficult to make particularly among the 'never married' nulliparous women. While the decision to abort is ambivalent, shrouded with conflict and confusion, it is thoroughly considered and takes long. This causes delay in seeking abortion services increasing the risk for complications and implied multiple costs. The abortion decision evokes a lot of pain, stress and agonies, that result in incremental delays from the moment pregnancy is suspected and at every step in the process of abortion-seeking. It does not matter that the pregnancy is the result of rape. For example Bi Wendi, the married woman with rape pregnancy struggled for three months,

> "I was thinking of options. It reached a point where I told myself "enough is enough, how long will I carry-on with this stress, hatred. No, I have to do it and live my life". It was a very painful decision to make". [*Bi* Wendi: 1 safe abortion; married; nulliparous; tertiary education; Mombasa City;]

Sometimes terrible nightmares fill the 'never married' nulliparous women with confusion and delays in service seeking as *Binti* Riziki explains,

[69][*Bi* Pendo: 1 unsafe abortion; married; 4 children; complete primary education; Kilifi Rural]

> "At night, I would get dreams; I would see my (late) father coming to me. Sometimes I would see a hearse brought and kept in front of me so I would tell my friends 'aaah wait a bit I think'." [*Binti* Riziki: 1 unsafe abortion; never married; nulliparous; primary complete; Mombasa City]

Repeat abortion decision may be even more challenging among the 'never married' nulliparous women. This is because although part or the entire situation may have changed little, the confounding guilt, moral and health considerations delays care seeking. *Binti* Maria's agony and confusion is a pull between the moral, the religious, and the praxis: "should I terminate the second one?" "Am I doing the right thing?" "Is it really good for my health?" "God forgive me", she describes her confusion,

> "I was confused because I did it the first time so I was debating 'should I terminate the second one?' I was asking myself 'Is what I am doing, right? Is it good for me? OK, even if my parents don't want (the man she was dating) am I doing the correct thing?' I just went. I found myself gone. I sat there; there were other people waiting to have abortion. I just looked at them, and then I decided 'No!' I went back home. I think after three days, I thought and I said, 'God forgive me' I went back again for the abortion." [*Binti* Maria: 2 safe abortions; never married; nulliparous; tertiary education; Mombasa City]

Despite their religious conviction that abortion is 'sin', and 'not right', these women choose the practical decision because it is necessary, inevitable, impelling in order to maintain self, family and community harmony. The accumulated delay in the entire decision-making process results in late abortion, a more expensive procedure, and increased risk of complications to the women. The section that follows, describes the context within which women seek abortion and the implications involved.

6.3 The Context of Abortion Access

6.3.1 Legal Status of Abortion

The findings in this study suggest that although the legal status of abortion in Kenya achieves little in stopping the women from seeking abortion services, it influences the type of abortion care. Abortion services thrive surreptitiously, invisible to the public, dangerous for "poor" women but safe for "rich" women. The women rely on private abortion services, formal and informal, because the legal position bar public health facilities from offering abortion services. Hence, legal barriers contribute to the inequities in the quality of abortion care obtained by women of differing social status.

Most of the urban and peri-urban women are vaguely aware of the legal restrictions of abortion. Some women cite incidences of police raids of some health facilities alleged to perform abortion. While some women mention the names of the facilities they visited for the procedure with ease, others are not comfortable doing so and we respect this. For example, *Binti* Maria from the City says, "you know if I mention the name, it is going to be another case (laughter)". "It can make you go to prison". However, most rural women unlike their husbands are unaware that abortion is "legally restricted in Kenya". For example, while arranging for his wife's abortion, *Bi* Rehema's husband discusses with the provider that, "…this thing is illegal in Kenya so we should keep it a secret between us". The married couples "…first visited the public hospital for pregnancy confirmation…" after which they go "…private, as public hospitals cannot terminate a pregnancy". Unlike her husband, *Bi* Rehema is surprised that abortion is legally restricted in Kenya and asks, "will the government feed your children for you?" Overall, abortion restriction is the least of women's worries perhaps because it has no direct bearing on their immediate social circumstances. This notwithstanding, the illegal environment for abortion heightens stigma and secrecy.

6.3.2 Abortion Stigma and Secrecy

Abortion takes place in the context of stigma and secrecy. The experience is a well-guarded secret throughout the women's lifetime regardless of the type of relationship or quality of care. Paradoxically, abortion is an "open secret" as women rely on social connections and support networks of women and men, sometimes including neighbours or even strangers in cases of emergency, and their providers; women can also share their abortion experiences in a study that assures them confidentiality. The involvement of these diverse players is evidence that not all society stigmatizes women who abort.

Notable differences exist with stigma being high for the women in unstable relationships and none for women in stable relationships as evidenced in the excerpt below:

Box 6-1: Excerpt from *Bi* Rehema's transcript

Interviewer: How does the community look at people who have terminated a pregnancy?
Bi Rehema: It is easy for people to know if you are unmarried but for me nobody knew.
Interviewer: How would they take/regard you had they known?
Bi Rehema: They will just say it is her life but if you are unmarried, they do not take it well.

Source: *Bi* Rehema's transcript/Kilifi rural/190605/KK2

For women in unstable relationships, particularly the "unmarried", "it is easy for people to know" that they have had an abortion. Although married and unmarried women have unsafe abortions that may result in complications requiring after care, the former are protected by their husbands, if they are involved in the initial decision making process, and who continue to arrange for treatment. On the contrary, the unmarried women are exposed to others who were not initially involved in the process such as family members, neighbor and sometimes strangers who intervene to save lives. So while in stable relationships, abortion secret may be confined between the couple and their provider, in unstable relationships, the secret may easily be exposed to others if complications occur.

"It is my secret. I have never told anyone about this matter. I would not want anyone else to know",[70] voices Bi Flora, the divorcee living in the peri-urban whose words echo the voices of other women participants. Confidentiality is an important factor in selecting the health facility. The women avoid the formal private clinics that they attend regularly in preference for the unfamiliar where they are not known to the 'doctor' (service provider). For instance, Bi Flora "felt free" to go to the private medical clinic nearest to her shopping centre because the nurse "did not know" her as "it was my first time to come here"; but avoided her regular private medical provider in Kilifi town because "I wanted it to be a secret," she said. Thus, distance from the health facility did not assure confidentiality but rather the woman's felt sense of trust. Some family doctors' are trusted to maintain confidentiality without divulging to the women's parents. In case of repeat safe abortions at the same facility, some women use different names to disguise their identity.

'The never married' nulliparous women keep the "big secret" from their husbands even after marrying if they aborted without his involvement. "The same man funny enough (laughter), is the one I have had the baby with, now we are married, but I did not tell him, I kept quiet. I did not tell anyone anyway. It was a big secret of mine", says *Binti* Hope. She aborted while in college because her then boyfriend seemed "non-committal" to their relationship. If they know the "channels to follow", the women go it alone because abortion-seeking is a "confidential issue" underscores *Bi* Halima in her conversation with the interviewer in the excerpt below:

Box 6-2: Excerpt from *Binti* Halima's transcript

Interviewer: Who accompanied you?

Bi Halima: I go alone for I don't want any other person to get to know that information.

Interviewer: What is the real reason why people do not want anyone to know?

Bi Halima: Those are very confidential issues, terminating a pregnancy; even someone explaining to you about it, do you know it is also confidential.

Interviewer: You are right, that is the reason I told you at the beginning that we are doing it in privacy and confidentiality is observed.

[70]For the interview team too, it was an oath we took to protect the secrets of these women even as we make public their experiences with the hope that women's health concerns will be taken seriously in policy and practice decisions.

Source: *Bntii* Halima's transcript/Kilifi peri-urban/080605/CK1

As she states this, *Bi* Halima is not aware that abortion is legally restricted in Kenya. This is instructive that confidentiality is informed by a desire for privacy as well to preserve one's reputation in a sometimes judgmental society, not necessarily the legal context of abortion. Asked why women keep abortion a "big secret", it is evident that social and not legal reasons preoccupy women's concerns. These concerns are linked to some men's negative perception of women who abort, underscores *Binti* Hope,

> "Sometimes when you talk about it there are some men who will not be ready to marry you because they will consider you a killer, because if you can kill an unborn baby you can kill him when he is alive maybe after an argument. You see if you have the courage to terminate a baby, then you can have the courage to kill a human being. Therefore, some people decide to keep quiet about it. Some women think if they talk about it, they will never get the man of their life you see they have to keep it a secret." [*Binti* Hope: 1 safe abortion; never married; nulliparous; tertiary education; Mombasa City]

Some men brand the women who abort "killer" and will not consider them as potential wives. Society views women as caregivers and nurturers of life hence fear the capacity of women to destroy life. This discourse is reminiscent of the Penal Code and the literature in Kenyan schools documented by Izugbara et al. (2009). Marriage and motherhood are important milestones for most Kenyan women despite the ubiquity of abortion.

Secrecy for legal reasons is certainly important for the medical staff arranging for or providing abortion services. "If you ever make the mistake and get pregnant again, do not come to me. Do not ever give out my name to anybody that I can help with such matters", retorts a medical staff member in a Mombasa hospital, whose nephew was responsible for *Binti* Sandra's[71] pregnancy in the Kilifi Rural; she arranged for an abortion following discussions with *Binti* Sandra's family.

[71]Standard 5 pupil; she dropped out of school and later married a different man.

Abortion stigma is real when society gets to know about the women who abort. *Bi* Neema narrates the shame she suffered, felt suicidal after some of her neighbours learnt that she aborted following complications,

> "I cannot sit outside there; I think you found me inside here going about my duties. Everyone looks at you and whispers, "That's the one who aborted" and sometimes you even think that you would be better off dead because everyone that passes points fingers." [*Bi* Neema: 1 unsafe abortion; separated; 8 children; complete secondary education; Kilifi Rural]

Abortion stigma is less and distress of unintended pregnancy minor among the women in stable relations. This is because pregnancy is a norm and abortion unexpected among the married women; therefore it goes unnoticed, says *Bi* Rehema, "it is easy for people to know if you are unmarried but for me, nobody knew". Nonetheless, secrecy is paramount as couples seek abortion. *Bi* Rehema and her husband visited the provider in the morning and the procedure done "by night". They did "not want people to know", because they (people) "will not understand", explains *Bi* Rehema's husband. For the relatives and neighbours enquiring about the women's illness, the couples explain it away as contraceptive complications or miscarriage resulting from acute malaria. The latter reason is a popular explanation among all the women seeking treatment following complications of unsafe abortion.

Paradoxically, despite delving into the secret depths of their lives and evoking their emotions, all these women find the study interview therapeutic, a catharsis. The women want to "…just to tell it out…" free up their pent up emotions with someone they trust will not judge them. For some of them it is because "I am saved[72] and I want it to come out of me because it has been disturbing me for a long time." Clearly, stigma and secrecy can contribute to the resultant psychosocial distress some of the women experience before and after abortion-seeking.

[72]To be "saved" is a term in the Christian doctrine that means personal repentance of sins and acknowledging Jesus Christ as Saviour.

The following section explores the four factors that influence access to and type of abortion care, and highlights the challenges these women encounter that constitute further sources of delay in abortion-seeking.

6.4 Access to Abortion Care

6.4.1 Financial resource continuum

Financial resources, rather than type of relationship (stable, unstable or none), are the major determinant of type of abortion accessed. "If you have money you will go to hospital, if you are poor like us, you will have to abort traditionally". This statement by Bi Nadia sums up the critical role of financial resources in determining the quality of abortion care accessed by these women (discussed in the next two chapters). Women obtain unsafe abortion, with high risk, not because they do not understand the dangers, or are ignorant of the formal health facilities offering safe abortion services, but for lack of "money".

Even when it is unsafe, abortion access is a financial challenge for most women in the urban, peri-urban and the rural areas. For some 'never married' urban women it involves negotiating with the 'doctors' to pay the service fees over a period of time. For other women, it means a vicious cycle of risk and vulnerability as they venture into 'illegal' trade because it is a readily available source of money. *Bi* Fatma's entry into sex work was in a desperate attempt to raise her first abortion fees. Reflecting on her first abortion, *Bi* Fatma the widow living in the peri-urban narrates how she desperately raised the Herbalist's fees,

> "You know how I got that KES 1,000, I just would get a man and negotiate and if it is using 'Trust'[73] we just go and I save little by little, I would rather stay hungry, get that money so that I can take it to that place, and get that service. In my heart, I knew what I was doing. You cannot believe it, life can

[73] 'Trust' is a male condom brand.

> be so tough." [*Bi* Fatma: 2 unsafe abortions; widowed; 2 children; Secondary Incomplete; Kilifi Peri-urban]

Indeed, "life can be so tough" for poor women seeking abortion. Earnings from sex work are unpredictable: clients can sometimes pay as little as KES 50, an equivalent of 750 ml of milk at the time of abortion! Women go to great lengths to obtain abortion. Sex work continues to be *Bi* Fatma's means of livelihood "I became a prostitute, moving from one club to another… to look for business". While sex workers are not always vulnerable, those who fail to use contraception and with limited financial resources are likely to have repeat unsafe abortions; abortion motivators may be inherent to their trade. In the absence of abortion they may have multiple children from different fathers and unsupportive partners. Many sex workers attempt to maintain a cohabiting partner while earning a livelihood from sex work outside. A case in point is *Bi* Fatma with 3 unsafe abortions in contrast to *Bi* Halima, also a sex worker with only 1 unsafe abortion and later 4 safe abortions when her finances stabilised.

Financial challenges largely explain why all the rural women in stable and unstable relationships rely on unsafe abortion. Statements such as "then you take time to get money, it takes a long time" are suggestive of financial difficulties among these women. In the rural area money is scarce as illustrated in how *Bi* Rehema's husband paid the fees over time and in kind, he recalls, "I did not pay the fees (KES 3 000) at once, in fact I did not have enough money and I had to give him a goat instead".

Safe abortion access is available to urban and peri-urban women in stable and unstable relationships with finances. The 'never married' women from financially "well off" families have no problem accessing safe abortion in "the best hospital in town", articulates *Binti* Maria who is from a "strict Catholic background", that is "rich" and "highly educated",

> "Cash to me is not a problem because I am from a family that is well off. I don't have any problem with getting money from my parents. And that time, I was also involved in group activities, like drama, so the little that I was

> earning at that time I did not find it very hard." [*Binti* Maria: Mombasa City; single; nulliparous; 2 safe abortions]

Similarly, for the women in formal employment abortion financing is their least concern; they just want the "pregnancy out", narrates Nurse Mwende, "...you know how desp..era..te [emphasizes] one gets, you just want it out, I could have paid anything because I had had it!"

Financial challenges can result in a continuum in abortion service seeking. Although *Binti* Mercy, a pre-university student is from a middle class family background, she first "tried many things" that "did not work" because she and her boyfriend are still dependents, she says, "I did not have the money because am not working, he is still in school, …" In her desperate efforts to procure a safe abortion in a "reputable hospital", because of her fear of resultant complications of unsafe abortion which might in turn alert her parents of what she was doing, she uses her wit to obtain money,

> "Somehow, I had to con my parents and cheat to get one thousand shillings and my boyfriend got two thousand. I don't know how he got it and I didn't care because what I needed then was the money seriously." [*Binti* Mercy: 1 safe abortion; never married; nulliparous; pre-university; Kilifi Peri-urban]

Clearly, availability of money determines the transition from unsafe to safe abortion. By the time women with no financial resources access safe abortion, they have tried unsafe methods at home and failed. Similarly, the women transition from unsafe abortion in previous pregnancy to accessing safe abortion in subsequent pregnancy following improvement in their financial situation. For example, at her first abortion by unsafe means in the Kilifi peri-urban *Bi* Halima was sixteen years, unmarried mother of one child; in the subsequent four abortions she has financial resources and knowledge about the availability of safe abortion in private hospitals in the Mombasa city where she obtains services. In some instances, failure of unsafe methods and lack of financial resources for abortion services causes women to carry pregnancy to term. During the study interview, *Bi* Fatma had her baby in her hands after the home abortifacients

failed ‘to work’ epitomizes the women who had unwanted child bearing as a result of lack of finances.

Summarily, among the ‘never married’ women participants reporting unsafe abortion, most of them are likely to have less years of schooling (primary complete or incomplete), are younger, with fewer opportunities for handling money, no assertive or negotiation skills and with less influential social qualities that are critical in navigating through financial challenges. Few have some secondary education and only one has college education. On the contrary, among the women participants reporting safe abortion, most of them have secondary school and college education therefore older, while a few have primary school education. The higher the level of education the more the likelihood of increased opportunities for finances, an expanded social network, and knowledge of available services and safe “channels to follow”; these are critical variables in accessing abortion as evidenced in the following discussion.

6.4.2 Social Connections and Support Network

6.4.2.1 The Role of Men

The rural women in stable relationships have the financial and emotional support of their husbands in seeking abortion. Besides the consultative decision making, husbands identify and arrange for the abortion with a provider, and sort out the service fees. Hence, the route to abortion access is significantly less distressing for these women and stigma reduced. However, lack of funding and poverty associated with subsistence farming and remoteness influences the unsafe abortion outcome. The few married women in the urban and peri-urban who abort independently of their spouses make arrangements by their own.

Among the women in unstable relations, all the separated women, half the divorcees and a few ‘never married’ women have financial support from their partners. However, except for two ‘never married’ women, these women’s partners are not involved in arranging for services; neither do they accompany the women. Most of the ‘never married’ women and the widow are lonely and “alone” having been “abandoned” by their partner or do not involve them at all. To access abortion services, these women seek the support of the womenfolk who are a repository of abortion knowledge.

6.4.2.2 Trusted female friends and relatives

Abortion is an "open secret" among "close" and "trusted" female relatives and friends. Relatives mentioned are maternal aunts, mothers, and sisters; friends, referred by most single women in the colloquial, "beste" are peers, that is, fellow students, neighbours, colleagues at work and hairdressers. Most often, friends/peers "had the experience before". Peers and hairdressers are the most commonly consulted by the 'never married' urban women. The social connections are empathetic and "understood" the need for abortion. They share in the distress of "abandonment", re-affirm the decision, advise pregnancy tests, identify the providers, accompany women to the providers, provide a hideout, prepare and administer the abortifacient, organise school transfers and maintain secrecy. They are also resourceful in providing information about types of providers available, describing the procedure and estimating costs of abortion services per trimester. They provide useful tips on "many different ways to go about it" (procuring abortions) for cheapest options where finances are a constraint, which is often the case. They advise on the benefits of early abortion, assist in paying abortion fees. Woman-to-woman connection to abortion access facilitates discounted service fees. Through her friend's connection *Bi* Fatma, the sex worker, paid discounted fees from the Herbalist, "He charged me KES 1,000 because that friend of mine who took me there is known to him, that's where she did her abortion as well, he is an expert". The women support each other on mutual trust and confidentiality.

It is evident that students discuss and consult with one another on pregnancy and related matters, a problem that they seem to share. Statements such as "there are friends of mine in the neighborhood that have aborted"; and "all of us were friends" are indicative of the prevalence of unintended pregnancy and induced abortion among the 'never married' urban women in the neighbourhoods and schools. Social connections facilitate access to safe abortion by fellow students with no money. Their schoolmates/peers from "rich family" offer to sponsor their procedure; some have sisters who are "working and able"; some are sponsored by their mothers; while others, through influential social connections, obtain free or nearly free services at the Coast Provincial General Hospital (*Makadara*[74]), a public referral and training health facility.

[74]The Coast Provincial General Hospital, CPGH, is widely referred to as *Makadara* by residents.

Previous clients of the provider are important social connectors to the formal institutions. Sometimes the women travel far to obtain services from private gynaecologists in Nairobi City after 'referral' by close friends/peers who previously obtained abortion services from the same place,

6.4.3 Knowledge (channels to follow)

Having the money is not enough to access abortion; the women in unstable relations must in the first abortion know the "right channels to follow" from the social connections discussed above, explains *Binti* Maria,

> "I was looking for the right channel, people to follow because this was the first time and I did not know the channels to follow. But I approached this friend of mine and luckily this friend of mine had already had abortion some months before. So she took me to where she had her abortion." [*Binti* Maria: Mombasa City; single; nulliparous; 2 safe abortions]

Finding these "channels to follow" takes long, causes further delays and increases the risk of complications. This is unlike repeat abortion where the women access services by themselves because they know "the place to go". Knowing the woman-to-woman connection provides critical links to accessing abortion services because often, they have previously aborted. Consequently, the type of abortion services the women access is similar to that of their connection. If their connection has an unsafe abortion, the women access unsafe abortion and vice versa. This is because the connection prescribes the same abortifacients, refers to the same provider and facilities they have utilised. It is a chain-link. However, for the married women, husbands make direct arrangements with the service provider. Sadly, geographical remoteness is a serious limitation to safe abortion access by couples and the separated women.

6.4.4 Geographical Location

Notably, access to safe abortion is unlikely among the rural women regardless of their type of relationship and partner support. While these women are financially poor, general marginalization in health infrastructure is a glaringly major limiting factor to safe abortion access. While the towns are inundated with formal private health facilities that women report as offering abortion, the hinterland has informal health facilities that women rely on for multiple health problems for the entire family. The distance, limited intermittent transport, and cost of travel to the towns is prohibitive for the rural poor. Furthermore, knowledge of the availability of private services in found in the urban is likely to be restricted.

The type of occupation has implications for the type of abortion procured. In the rural area subsistence farming is the major source of livelihood while some husbands resident in the urban areas have opportunities for formal employment. Thirty-three year-old *Bi* Munira, a Muslim homemaker and mother of five children, with no formal education, residing in the peri-urban procured a safe abortion with the support of her husband who is in formal employment. Even where the married women independently abort they can afford safe abortion if the husband is in formal employment. For example, *Bi* Chesi a homemaker residing in the Kilifi Peri-urban used savings from her kitchen kitty, that her husband "normally gives" her because he is in formal employment.

Nonetheless, where the urban married women or their husbands have no formal employment, women are likely to access unsafe abortion. For example 19 year-old Bi Nadia, a Muslim mother of two children, with primary education, and working in informal employment as a salonist (small scale hairdresser) in the City obtained unsafe abortion. For the urban women, affordability, rather than accessibility to private health facilities determines the type of abortion obtained. The experiences of these married women are particularly important in dispelling the myth that unsafe abortion is a problem of unmarried adolescents only.

Even when they have limited finances, the urban women in unstable relationships who have a consistent income from their employment are able to borrow money for a safe abortion. At the time of the interview, *Bi* Flora was still paying her debt (KES. 4,000) by installment and "the

problem is now solved, I feel free now". However, as noted in the previous section, residence in the urban area is no guarantee to accessing safe abortion. The urban 'never married' women report as much unsafe abortion as they do safe abortion.

6.5 Summary and Conclusion

This Chapter on the social and legal issues impinging on abortion-related decision making by women in Mombasa city and the Kilifi district lead to the major conclusion that: while legal barriers do not prevent abortion, they succeed in entrenching inequities in abortion care access, condemning the most vulnerable groups of women, who are the majority in Kenya, to unsafe abortion while the few with financial resources access safe abortion.

In a legally restricted context, financial resources are the major determinant of type of abortion accessed by women regardless of type of relationship with men. Financial challenges can result in a continuum in abortion access. Hence, transition from unsafe to safe abortion or from unsafe abortion to unwanted childbearing. Having husband financial and emotional support guarantees no access to safe abortion if he relies on subsistence farming, is geographically remotely located, or has no formal employment. Geographical remoteness is a serious limitation to safe abortion access by women in stable and unstable relationships. Women who are in formal employment are likely to procure safe abortion.

Women of diverse socioeconomic and cultural backgrounds have safe and unsafe abortion. However, women who are young, with less years of schooling, who have no access to financial resources, those with female connections that have aborted unsafely, or reside in the rural areas are likely to have unsafe abortion. Conversely, women who have secondary education and above, reside in the urban or peri-urban areas, with female connections that have previously safely aborted, are likely to have safe abortion. The womenfolk are a repository of abortion knowledge. Conclusively, the route to induced abortion is complex and replete with incremental delays at each stage in the process of service seeking increasing the risk for complications and implied multiple costs. These delays explain why second trimester abortions are a common feature

among the few women survivors admitted in gynaecological wards for treatment of complications.

Whether a relationship is stable or unstable influences how women make the abortion decision. The married women make a consultative decision with the husbands taking the lead in their role as health financiers. Given the urban dynamics, a few married women make an independent decision to abort just like women in unstable relationships. Most 'never married' women do not involve their male partners because they are unlikely to receive financial support from them. Male partners have no control over abortion decisions outside marital relations even in the few cases where they are involved in financial support.

The abortion decision is difficult to make and thoroughly considered. Among the 'never married' nulliparous women, the decision to abort is ambivalent, shrouded with conflict and confusion, and takes long even when it is a repeat abortion or a rape pregnancy. However, the women's decision to abort overrides their religious conviction and legal restrictions because it is necessary, inevitable, impelling in order to maintain self, family and community harmony. The women ensure confidentiality because they desire privacy, preservation of their reputation in a judgmental society, and avoid threat to future marriage. Legal barriers heighten stigma and secrecy. Abortion is an "open secret" and not all society stigmatizes abortion, which indeed is ubiquitous. Paradoxically, abortion stigma and stress are less when it occurs within the confines of marriage because it is not viewed as a rejection of motherhood. Unlike the unmarried women, the married have proven fertility. Another paradox is that abortion study interviews are therapeutic, a catharsis for the women despite delving into the secret depths of their lives and evoking their emotions. In the chapters ahead, I compare and contrast women's experiences of safe and unsafe abortion.

The Figure 6-1 below encapsulates the complex, interactive and interlocking issues involved in the process of seeking abortion discussed in this and the previous chapter. The diagram attempts to capture the constructs, defined and conceptualised from the women's experiences presented in the data.

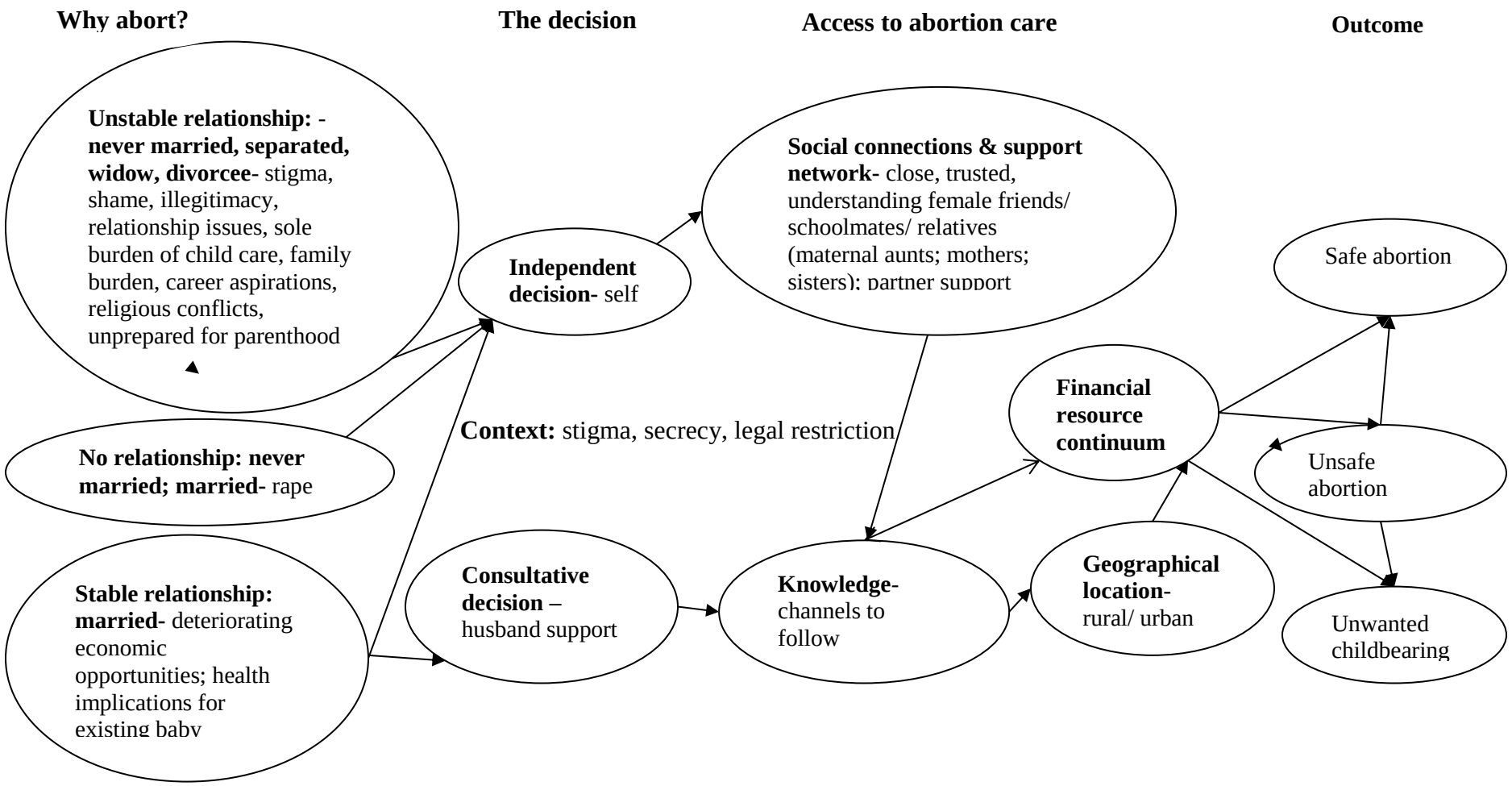


FIGURE 6-1: THE ROUTE TO INDUCED ABORTION ACCESS

CHAPTER SEVEN

7.0 SAFE ABORTION EXPERIENCES

"*…life continued as normal*"

7.1 Introduction

The discussion in this chapter seeks to respond to the question: what are the experiences of safe abortion among women in Mombasa and the Kilifi districts? The Constitution of Kenya, 2010, like the previous Laws of Kenya (2008) permit safe abortion in circumstances where, in the opinion of a trained health professional, continuation with pregnancy threatens the health or life of the mother. Comprehensive abortion care Standards and Guidelines by the Ministry of Health (2012), informed by the Constitution of Kenya 2010, now exist. Yet, empirical evidence on safe abortion in Kenya, even where the law permits, is difficult to find in scientific literature. Safe abortion, albeit surreptitious, is available largely in private formal health institutions and proprietor clinics in the cities and small towns in the country as evidenced in this study. In what follows in this chapter, I analyze the settings in which abortion occurs, the types of providers and the methods used in a safe procedure. Some of the sub-topics used in this and the next chapter are borrowed from Adeokun's proposed framework (1991) for the determinants of abortion outcomes in Nigeria. It is under these sub-topics that I develop, describe, and model categories and constructs from women's emic experiences to increase our understanding of the pathways to safe and unsafe abortion outcomes and compare and contrast the two. While interesting, it is not the present intention of this thesis to explore Adeokun's biomedical framework against the one developed in this study findings based on women's voices. These findings are discussed in comparison to the WHO recommended standards of safe abortion provision aimed at minimizing injuries and thus to enhance maternal survival. This chapter concludes with Figure 7-1 that captures the constructs in the sequence of events to facilitate understanding. But first is a brief description of the type of women seeking safe abortion.

7.2 Characteristics of women seeking safe abortion[75]

Out of the 64 reported abortions by the 49 women, 31 were aborted safely. This implies that there are nearly as many safe abortions as there are unsafe ones among women who served as study informants. Twenty-two out of the 49 women have their first abortion by safe means. Seven of these women are already mothers at first abortion: 3 are married, 2 are divorcees and 2 are 'never married'. One married woman has no child at the time she aborted the rape pregnancy by an acquaintance. The rest 14 women are 'never married' and nulliparous at the time of first abortion. With the exception of the 3 women with rape pregnancies, the rest of the women (19) were not using an effective means of pregnancy prevention at the time they conceived the aborted pregnancy(ies). Seven of the women are under 20 years of age, another 7 are between the ages of 20-24years while the rest 8 are between 26 and 33 years old at first abortion; these women are students in secondary schools, tertiary colleges, their partners/ 'breadwinners' are in formal employment, or are in formal employment themselves, or have their own informal businesses. The women who have safe abortion are likely to be those resident in the Mombasa city or the Kilifi town and peri-urban areas with close proximity to formal health facilities. The women resident in the rural area, regardless of their type of relations with men, report no safe abortions mainly due to geographical remoteness from formal institutional settings.

7.3 Institutional Settings

7.3.1 Informal settings

Unfortunately, by the time most women seek services from a provider in formal settings, they often have tried 'first-line' homemade herbal concoctions and 'second-line' pharmaceuticals in informal settings. The informal settings can be the woman's home, her parents', her friend's, some other relative's, or that of the man responsible for the pregnancy. Lack of money, sometimes accompanied by knowledge of "channels to follow" to procure a safe abortion prompts women to first seek these seemingly cheaper alternatives even when they understand the consequences of these methods. It is when these self-inducing efforts fail that women proceed to

[75] see Appendix I: Characteristics of the 49 Women Participants, Tables 1a-e, 2 and 3

the hospital or clinic for skilled assistance. Hence, as discussed in the previous chapter, there is a continuum of service seeking leading to a safe abortion. The use of alternative treatment methods for other ailments is a generally common health seeking practice among women in communities in Kenya. Health seeking in formal health facilities is sometimes a second option.

Herbal concoctions ("kienyeji") include household traditional practices that are employed because they are known to "work" in terminating unintended or unwanted pregnancy before seeking professional help. For example, *Binti* Mercy "really did a lot of things" such as she drank concoctions from boiled roots, that she had "some idea" about but they failed to work; then she swallowed "some pills" from the chemist (dosage: 8 tabs per night for 3 days) but these "did not work". Fearful of 'street' procedures, that her parents might find her out in case of complications, she then scrounged for money and sought hospital services. This is women's turning point towards formal settings, and safe abortion. In the transition process, women keep secret their self- attempted methods.

A small category of women with adequate financial resources, who are aware of the channels to follow, and reside in urban or peri-urban areas, do not attempt abortion in home settings but directly visit their chosen hospital in the city. Hence, different women experience safe abortion differently with those having financial difficulties attempting unsafe methods initially before proceeding to a formal health facility for safe abortion after availability of funds. This aspect of some women first seeking alternative methods of abortion before seeking care in formal settings lacks in the Adeokun's (1991) model which assumes a direct care seeking in formal facilities.

7.3.2 Formal institutional settings

Formal health institutional settings or locations meet the minimum medical standards (Adeokun, 1991), are licensed to operate, and are registered with the Ministry of Health (MoH), Kenya. Additionally, these institutions regularly submit the comprehensive post abortion care (cPAC) reports to the district health information office, the MoH. Both public and private health facilities, including hospitals, nursing homes and clinics in the cities of Mombasa, Nairobi, Eldoret and the Kilifi town and peri-urban, are mentioned by the women as providing safe abortion services surreptitiously. However, unlike the private hospitals, the public health

facilities have no protocol for women seeking abortion care; instead they provide only individual medical staff who offer clandestine services on weekends. For example, *Binti* Joyce, a secondary school student pregnant after a gang-rape, innocently sought abortion services in a public health facility. The providers in the first health facility, the then Tudor Health Centre, turned her away advising her to keep the baby. In her determination to abort, as is characteristic of women seeking abortion, an acquaintance arranged for her abortion services with a specific provider at the Coast Provincial General Hospital (CPGH). The procedure was done on a weekend, inexpensively for an unofficial fee of KES 500 (approximately USD 7.00); some women reported paying nothing. Thus, women who are well connected to persons influential to medical providers at the public health facilities may obtain abortion services secretly.

Formal private health facilities follow routine protocol as they do for other medical services they offer. "To them it was routine, just another normal medical procedure", observes Nurse Zainab. Sufficient evidence of demand for abortion services in formal private institutions exists. "I sat there; there were some people who were also going to have abortion", observes *Binti* Maria. As discussed in the earlier chapter, these women are 'referred' to these institutions by fellow women who have previously obtained similar care. Administrative protocol entails payment of official registration and consultation fees, followed by opening of the patient file at the reception. Pre-abortion care constitutes the basic clinical examination such as a urine sample laboratory test for pregnancy, blood samples perhaps to measure haemoglobin, and measurement of blood pressure. Some women mentioned drug prescriptions which I assume could be prophylactic antibiotics and analgesics. Pre-abortion counselling is mandatory in some hospitals which seem geared towards giving women a chance to rescind her decision. Unfortunately, these sessions take the form of a video illustrating the procedure, "it was ugly, you see the baby in pieces and it is scary". It explains "the risks of surviving and dying because of bleeding" and aims at instilling fear rather than giving facts. After the video session, some hospitals allow the woman time to reflect by giving her an appointment for the following day.

Given the above protocol, it is not surprising that despite having had safe abortions, some women remain traumatized with concerns about their future fertility. In addition, these women find the concept of 'safe' abortion hard to understand, thanks to the scare tactics. While abortion

must not take the place of contraceptives, this type of selective counseling is questionable and not in line with current proof that the latest medical technology renders abortion safer than childbirth, more so in developing countries where skilled midwifing is not available to the majority of women (Sedgh et al., 2007). In the absence of the video session, private providers interrogate the individual women about their motivation for abortion before offering "help". For example, Nurse Zainab was asked by the provider if she was "really ready for it because there are consequences and side effects". Women are categorical that the decision to abort is personal and a responsible one, therefore it is important that providers exhibit sensitivity in the matter. Clearly, women dislike the interrogation and prefer that their decision be respected as seen in *Binti* Halima's defense below,

> "Yes, they ask you "Why do you want to terminate the pregnancy?" I told them because of my problems, "What problems?" I tell them "my problems I know them myself, since I have children to take care of and have no husband"". [*Binti* Halima: 1 unsafe abortion; 4 safe abortions; married; 4 children; Primary incomplete; Kilifi Peri-urban]

Pre-abortion counselling must be voluntary, unbiased and empowering to enable the women to make an informed decision. Nonetheless, there are special cases where administrative protocol is not followed in private hospitals. In an interesting case, the provider performed a hurried "backdoor" abortion on a fellow medical staff during off-peak hours in the evening in the absence of the hospital management. The woman receiving the abortion paid subsidized, fees with no receipt issued. Nurse Mwende, a nurse in a public district hospital, explains her case laughing,

> "(Laughter) What I can tell you is that my case was like a 'backdoor' story or if I can so call it. Because when I went there the first person I met was a nurse. So I introduced myself to her; I told her I am also a nurse working for the Ministry but I have come for this service. Then she realized that since I am a colleague she cannot take me through the whole procedure so it (formality) does not matter. I was eight weeks so she said, "I will perform it". So I told her "are you very

> confident" because it's something very delicate, she told me, "am OK". It was about ten in the morning so she told me to "come back at 6:30 pm since the managers will not be there, I will do it silently and then you can pay later". So I did not even enquire about the charges. But you know how desp..era...te (emphasizes) one gets, you want it out, I could have given anything because I had had it!" [Nurse Mwende: 1 safe abortion; never married; 1 child; Tertiary education; Kilifi Peri-urban]

As a professional nurse, Nurse Mwende knew that not every medical provider is skilled to perform abortion, an awareness other women lack. Hence, she inquires of her colleague's capacity to handle the procedure. The women of higher social class or with ample finances have their choice of sophisticated health institutions in Mombasa City and as far as Nairobi City where they are assured of high quality services. Hence they secure their future fertility, explains *Bi* Masahaka,

> "Actually, me I did it in a hospital in Nairobi. This was 'cause I really had to take precautions and be safe. I did not want to do it in the back street or medicine people. Because I have heard of people doing it there and ended up having complications and never giving birth so I went to hospital. I am glad money that time was not a problem and I had a gynae so I went to see him. We discussed I told him everything; I was booked in a hospital and it was done in a safe way". [*Bi* Mashaka: 2 safe abortions; married; 1 child; Secondary complete; Kilifi Peri-urban]

The degree of protocol complexity varies depending on the setting (Adeokun, 1991). Facilities located in the city centre range from simple to elaborate procedures therefore they are more costly compared to those located in the peri-urban setting which have simple procedures and are less costly. Women describe the clinical environment and tools as sanitary and the attitude of the provider as appreciable or "okay" as they put it. The health facilities are also well furnished with medical supplies and equipment albeit of varying levels of sophistication. The health facility

setting is very important as women associate it with the technical competence of the provider, and therefore assured safety and future fertility.

7.4 Technical Competence

The competence of the provider directly influences safety (Adeokun, 1991). The cadre of medical staff in the formal institutions includes private medical doctors, nurses and clinical officers. Some are women's private gynaecologists, family doctors or doctors well acquainted with the families of the women because they operate in the densely populated small shopping centres along the highways, or private nurses completely unknown to the women. The women's descriptions of the provider, the district health information office records on post-abortion care technology training and returns, key information from the private and public medical personnel and public health professionals, and our knowledge of the hospitals and clinics, form the basis for deducing the skill of the providers in various formal institutions. They observe that "many doctors provide abortion services in the city centre". However, these medical personnel are very cautious and remain publicly anonymous due to legal repercussions. "Therefore, you may go there and they ask you many questions such as "who told you?" Providers in public health facilities are wary too and they ask, "How did you know I do those things for people?" But "when you go there and ask properly and secretly for the doctor, they will do it for you (*utafanyiwa*)", explains *Binti* Farida.

Abortion is not only a social crisis but a public health one as well. Some medical providers are willing to intervene but find themselves constrained by the law. Desperate women implore providers for "help" and sometimes look for specific medical providers known to them, as in the case of *Binti* Grace who notes, "I looked for one Clinical Officer (male CO) and talked with him, he did not want but he had to. I told him, 'You must terminate this pregnancy'." *Binti* Wasai also says, "…we really tried to force him. He does not want". While the providers "understood" the desperate circumstances in the plea for "help" by the women, their relatives and, couples, the women's stories illustrate a sense of reservation or unwillingness on the part of the provider to

perform abortion, contrary to popular belief that providers cash in on the demand. Certainly, the legal repercussions largely explain this reluctance. *Binti* Wasai recalls,

> "He was thinking twice about it because he is someone who since we were young he used to treat us. He said he does not usually do abortion but my aunts told him to help us this once only. That is how he agreed to help me." [*Binti* Wasai: 1 safe abortion; never married; nulliparous; Secondary school; Mombasa City]

However, some private providers, prompted by the huge demand for treatment for abortion-related complications in their institutions, create awareness of their surreptitious safe abortion care. Emphasizing the distinction between competent providers and 'quacks', private providers caution the women against unsafe procedures in an effort to avoid maternal injuries with serious ramifications, *Binti* Farida explains,

> "When I went to have the 'washing' at (name of hospital), they told me 'why did you not come here for the abortion, we provide abortion services. Now you have gone there and you have gotten yourself a lot of problems you do not know where or what was poked. Here, if you come we do the abortion at once and we 'wash' up everything'." [*Binti* Farida: 1 unsafe abortion; never married; nulliparous; Primary complete; Mombasa City]

The argument by the private provider underscores the futility of the abortion law which facilitates increasing maternal injuries and deaths among the vulnerable women. Sadly, a few case of medical malpractice traumatizing the vulnerable women are identified such as attempts to "date" and giving the woman the products of conception to dispose of them herself as *Binti* Grace narrates of her first abortion when she was a secondary student and unmarried (in her second abortion she had completed Secondary school and was married),

> "The doctor (read Clinical Officer) showed me what came out from inside there (foetus) you see. Ah! On seeing that I felt so much pain, to date it is still in my mind. I can't forget. Then he said to me 'carry this yourself go throw it away'

(looked disturbed then laughed sadly)." [*Binti* Grace: 2 safe abortions; never married; 1 child; Secondary student; Mombasa City]

Some providers, particularly the small proprietor clinics in the peri-urban area like the one *Bi* Flora visited, give woman-friendly care, inform the women about what to expect, and how to take care of themselves during this time; prescribe recommended antibiotics and analgesics and encourage them to revisit the clinic in case of any concerns, which they often did. "She told me 'if you experience any discomfort or problem you come back'. And I didn't see any problem." However, some providers who do not follow these WHO recommended guidelines cause pain and public embarrassment to women. After her second abortion at mid-trimester, *Binti* Maria explains that,

"The first abortion I didn't feel anything, but with the second one, I had some pain in the abdomen and after one week I bled. I was going to town in fact I was in this jeans and I had taken a bath I was going to town, but as I walked out of the house, blood started flowing so I had to rush back to my bedroom, locked myself because at that time my mother and my dad were around, the three of us. So I had to go back, I locked myself till the bleeding stopped. I took off my clothes, had a bath and…I just sat there I didn't go to town again. Since that day up to now I haven't had any complication." [*Binti* Maria: 2 safe abortions; never married; nulliparous; Secondary complete; Mombasa City]

Similarly, Nurse Mwende experienced excessive bleeding which she suspects was the result of the irregular protocol applied by the provider, she explains,

"So at six o'clock I went, she was waiting for me; she had prepared. May be she was doing it in a hurry, she did not want to be found, she must have affected some veins because I bled, at night I really bled but in the morning I expelled a few drops, you know these products of conception but later I was ok." [Nurse Mwende: 1 safe abortion; never married; 1 child; Tertiary education; Kilifi Peri-urban]

As a medical professional, Nurse Mwende knows the provider's conduct is "wrong professional practice" but does not blame her colleague because she understands the circumstances and laughs it off as she said,

> "(Laughter) I tell you it was quite hopeless because she did not even tell me to expect bleeding she just told me "put an additional cotton wool, you just go…" like she was in a hurry, I just got out of the door and closed it. Deep in my heart I know it is wrong and maybe she also knows it is wrong professional practice but of course… (She gestures in dismissal)". [Nurse Mwende: 1 safe abortion; never married; 1 child; Tertiary education; Kilifi Peri-urban]

7.5 Technological Aspects

Technology refers to the mode of operation of the abortifacient on the product of pregnancy (Adeokun, 1991). The mode may be chemical or physical. Technologies that are less physical tend to have more successful abortion outcome (Adeokun, 1991). Most women describe procedures that resemble the manual vacuum evacuation popularly known as the MVA and, less frequently the D&C techniques[76]. The MVA is the WHO recommended abortion technique for up to 12 weeks pregnancy and some skilled providers use it for up to 15 weeks (WHO, 2003a). At the time of Nurse Mwende's abortion the MVA kit was available in public health facilities, but the medical staff was still ignorant of it, she says, "That time I never knew about the MVA kit yet we (at the public hospital) used to have it." Some women used descriptive words such as "another thing like a straw she put or inserted then withdrew it, it came out"; "she (doctor) was busy inserting the pump inside me". A description by *Binti* Francie of the method used in her second abortion is more vivid.

> "He tied my legs, it is like everywhere that is what they do, he tied my hands too and inserted that metal to open the cervix, then he took another tube and inserted

[76] The reader may refer to the WHO Technical on safe abortion for more details

> and it was stirring inside there, it is painful. It is painful, and then it fills up he goes empties the syringe and inserts again and on and on." [*Binti* Francie: 1 unsafe abortion; 2 safe abortions; never married; nulliparous; Secondary student; Mombasa City]

They may not know the name of the procedure, but from their description of the instrument and how they felt it work, it is clear that it is the MVA. Although safe, some women like *Binti* Francie protested against the discomfort, and undignifying positioning and intrusive nature of the MVA procedure. In addition, the procedure is painful indicating that analgesics are not used in most settings. For the majority of these women, this is their first gynaecological experience; therefore more sensitivity is required in their care, but it is lacking.

Description of intrusive methods by some of the women with mid-trimester abortions I assume to be D&C (dilatation and curettage). Terms such as "metals" that made them "very scared" and apprehensive, saline water drip or labour inducing drug, Cytotec, the drug most commonly used to relax the cervical muscles for ease in dilatation, were described. The D&C is no longer recommended for first trimester (12 weeks) abortion because it is less safe and more painful for women than vacuum aspiration (WHO, 2003a). Dilatation and evacuation (D&E) is the recommended technology for over 12 weeks' pregnancy (WHO, 2003a). The women discreetly report to the hospital in the dusk, *usiku usiku*, and are booked for overnight D&E and observation, underscoring the clandestine operation.

Early abortions (first trimester- up to 12 weeks pregnancy) are more common than late abortions (second trimester- more than 12 weeks) among the women studied. However, even early abortions are in the late first trimester (estimated 12 weeks) because of delays in the decision-making process. The earlier the abortion the more reduced is the risk of complications for the women. The women find the MVA procedure to be impressive, simple, pain-free in some health facilities, and quick. The women commend the efficiency of the MVA and are happy with the result of a complete, neat abortion with no "bloody messy" outcomes and painful complications commonly associated with abortion. Amazed by the procedure *Bi* Flora who visited a less sophisticated proprietor clinic in the peri-urban area narrates, "when she was done, I went home

and started wondering, “Did I just have something done really?” I just felt normal”. Similarly, Bi Hope who visited a more sophisticated hospital describes how she was put under general anaesthesia, “slept” and in about half an hour “I woke up and went to work”. Of note is that the WHO recommends local and not general anaesthesia for the MVA procedure which should ideally take fifteen minutes. Legal barriers perhaps compromise the monitoring of providers in hospitals to ensure compliance with recommended guidelines.

An important conclusion to the above discussion is that, despite hurdles experienced by some women, competent providers perform the procedure without any physical or reproductive damage. In other words, they have a safe abortion. What follows is a brief comment on the abortion aftermath as it has implications for post-abortion counseling.

7.6 Abortion Aftermath

The effect of abortion on women varies in extremes, regardless of abortion type. The women whose abortions had taken place in the distant past demonstrated more emotional stability during the interviews than women whose abortions were more recent (for all women regardless of abortion type). Generally, women suffer high degree trauma before the abortion, but afterwards most express immediate relief as in “life continued as normal”. Safe abortion brings joy and relief and provides the woman “another chance” at life. *Binti* Zilda says,

> “The next day after I had aborted I felt better. You know how you just sleep feeling so nice that at least things are better now and I am so well (she laughed) and I do not even remember, although it is something you can never forget.” [*Binti* Zilda: 1 safe abortion; never married; nulliparous; Tertiary education; Mombasa City]

The classic case of *Binti* Mercy illustrates the mix of relief and trauma some religious (Christian) women experience soon after an abortion. At the time of the interview, two weeks post abortion her emotional distress and trauma was still very raw and clouded the session. Yet, *Binti* Mercy had felt immediate relief after abortion as her reflective words suggest, “You know (Raises her

voice) by then yeah, you are really happy that you have gotten rid of it now OK life is back to normal". Before the abortion a woman's mental energies focus on the means to abort pregnancy regardless of her religious values, but when suddenly the source of distress is no more, the focus changes to the reality and meaning of the abortion on her religious and cultural values. *Binti* Mercy explains, "When you really want to do it, it does not hit you, it hits you after you have done it that's when you know now I have done something wrong and I tell you it really hurts". She needed time alone to process her thoughts and "to adjust to my new condition". Multiple thoughts caused her mental anguish among them, her religious values, "when somebody is religious like me I really know I did something wrong". She castigated herself for "killing a kid" that would have given her the only chance at motherhood because she feared God would punish her with infertility.

> "Even like yesterday I had one of those moments that's sort of like God just hates you, you know; it also hit me that really, maybe that's the only kid I would ever have in the future. You know it scares me. Maybe God had given me that only chance to have a kid really so it's like OK I will never have kids again. Maybe I might have some problems in the future (raises voice). Maybe that kid would have been a great thing in this world (continues crying). The only thing you can do is just curse! You curse that man, you curse yourself. You curse everything (crying)." [*Binti* Mercy: 1 safe abortion; never married; nulliparous; Tertiary education; Kilifi Peri-urban]

Despite safe abortions, the fear of threat to "future fertility" as a divine punishment agonizes some single Christian women who are nulliparous. Similar feelings of guilt are reported among Nigerian women who became infertile as they felt God had punished them for the crime of abortion (Oye-Adeniran et al., 2005:139). Extensive review of scientific literature consistently reveals that women who abort their first pregnancies by MVA are at no increased risk of failing to conceive at a later date (David, 1992: 8). Some women decline to have counseling because of the desire to "forget about it". For example *Binti* Mercy wanted to focus on her studies "I have my books to think about", she continues,

> "The more I talk about it the more I keep on remembering about it and the more it hurts. Now like today I just have to spend another night awake, seriously, I cannot sleep with these things in my head, it is too much... (continues to cry)" [*Binti* Mercy: 1 safe abortion; never married; nulliparous; Tertiary education; Kilifi Peri-urban]

Time would heal her trauma as it did other women who had taken the same route before her. Nonetheless, it is my hope that the talking she braved during her interview was therapeutic, as most women allude, and therefore she will again achieve sound sleep. The foregoing underscores once again that even after safe abortion women's preoccupation is about the security of future motherhood. These are implications for post-abortion contraceptive counseling to reduce repeat unwanted pregnancies and reliance on abortion for fertility control.

7. 7 Family Planning Counselling

Post-abortion family planning counselling is recommended after safe abortion to avert unwanted pregnancy. Although there is evidence that most private formal health facilities provide post-abortion family planning, it is sporadic and the quality of the services do not measure up to the standard guidelines recommended by the WHO (2003a) and outlined in the Family Planning Service Provider Manual, the Ministry of Health, Kenya (Ministry of Health, 1997).

Family planning service delivery is provider-centered perhaps motivated by the availability of supplies and provider attempt to curb repeat abortion. The women's narrations told of, "after doing the abortion they encourage you to take pills", and, "after that, they will give you the Depo (*sindano* or injection) even if you don't want, it's a must". The Depo is forced on parous women suspected to have repeat abortion. The women visiting the facility for repeat abortion use a different name as a disguise, "so when I went there for the second time I had to change my name, because they are very strict". Bi Halima, a 'married' woman with multiple children, declines the Depo because she believes she has hypertension and diabetes. Providers should take time to listen to and address women's concerns and advise them appropriately, rather than be

preoccupied with prescribing family planning methods. Thus, the women have repeat abortions because they fail to use post-abortion family planning.

The young nulliparous women in non-marital relationships have negative attitudes towards family planning methods. The fear of threat to future fertility as a contraceptive side-effect is among the greatest barriers to using various methods to avoid pregnancy. *Binti* Mercy's views are representative of many others, "I really don't like them much; I don't know why. I also have a negative thing about them. Don't you think I am too young to start taking such things?" Like *Binti* Mercy, most single women in the study prefer post-abortion abstinence. However, based on the large frequency of repeated unwanted pregnancy, abortions and unwanted childbearing that were reported in this study, it is obvious that sustaining abstinence is a challenge for these women. The married women and women in non-marital relationships with at least one child are more likely to embrace family planning than nulliparous women. For example, although Nurse Mwende, parous, received no counseling for family planning, being knowledgeable, she visited a different clinic to obtain the Norplant, a hormonal method of birth control. There is consensus among women and the providers that hormonal contraceptives threaten the fertility of nulliparous women. *Binti* Hope expresses her fear which echoes that of other women,

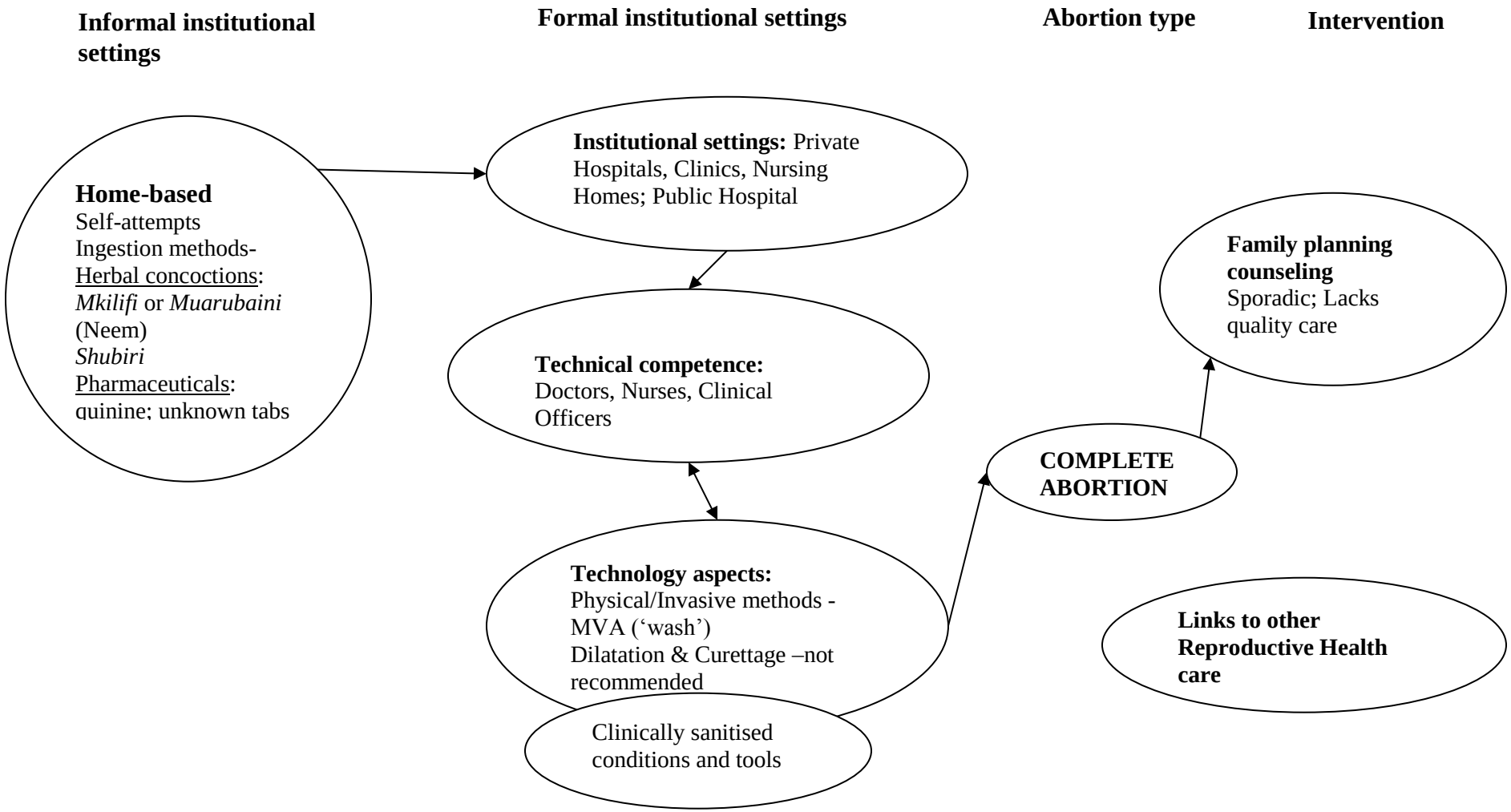
> "If you are not married I prefer you use a condom 'cause if you use contraceptives after sometime they can affect your womb and giving birth again I know it's a problem. They [providers] don't advise people to do that. The advice is that one should use them after you have delivered at least once." [*Binti* Hope: 1 safe abortion; never married; nulliparous; Tertiary education; Mombasa City]

These concerns are a clear indication of the need for quality family planning counseling by providers. Additionally, there exists opportunities for the promotion of effective condom use by nulliparous women in non-marital relations for pregnancy prevention. Notably, no further information or referral for other reproductive health services is provided as required by the post-abortion package.

7.8 Summary and Conclusion

The Figure 7-1 below encapsulates the above chapter. Access to safe abortion in Kenya is exclusively available for women with finances regardless of their type of relationship with men, stable, unstable or none. There exists competent medical staff in formal private health institutions of different levels located in the urban and peri-urban areas of the study willing to provide safe abortion, albeit surreptitious. Due to financial difficulties, some women follow a health continuum in abortion-seeking. They first make self-attempts to abort; failure leads them to seek professional care. The simple MVA applied for most abortions give the women immediate relief. This chapter demonstrates that safe abortion poses no threat to women's health. However, the quality of post abortion family planning is compromised. Perhaps the legal environment hampers adherence to the Standards and Guidelines for comprehensive abortion care by private and public providers. Hence the reported abuse, pain, reduce trauma and repeat abortions. Opportunity exists for the promotion of the condom as a dual protective method among the nulliparous. The chapter that follows discusses the women's unsafe abortion experiences for comparison and contrast.

FIGURE 7-1 WOMEN'S EXPERIENCES OF SAFE ABORTION



CHAPTER EIGHT

8.0 UNSAFE ABORTION EXPERIENCES[77]

"…there are two things, dying or surviving"

8.1 Introduction

The analysis of data in this chapter and the one that follows seeks to answer the next question of investigation cited in Chapter One: What are the experiences and consequences of unsafe abortion among women in Mombasa City and the Kilifi district? Unsafe abortion is the major cause of maternal morbidity and contributes to more than one third (35%) of maternal mortality in Kenya. Due to legal restrictions, abortion services thrive surreptitiously, invisible to the public, dangerous for "poor" women but safe for "rich" women. Legal barriers limit abortion literature in Kenya with studies focusing on epidemiological prevalence, incidence and medical sequelae using records of survivors seeking care in public health facilities following complications of unsafe abortion (African Population & Health Research Center et al., 2013; Gebreselassie et al., 2005). This chapter uniquely fills the gap giving voice to the untold story of how women seek unsafe abortion care, the source of the complications, the sufferings they experience, before reaching the health facility for treatment, if at all and elucidates on why some survivors fail to seek post abortion care. This includes the married women who are rarely featured in abortion literature in Kenya. It depicts their experiences in prolific informal institutional settings, characterized by unskilled providers, use of improper tools, and poor sanitary conditions. In so doing, I hope the voices of these women will stir the need for policy change to reduce maternal morbidity and mortality. The Flowchart 9-3 encapsulates the findings in this and the next chapter.

[77] Some data in this chapter is published in an article authored by myself. The abstract is in Appendix VII. Part of these findings were disseminated at the 8th International ECSAOGS Scientific Conference, Whitesands Hotel, Mombasa 18-22 February, 2009; and at the 2nd African Conference on Sexual Health and Rights, Nairobi 19-21 June 2006; and at the 8th Postgraduate Conference, Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal, October 28th, 2006

8.2 Characteristics of women seeking unsafe abortion[78]

Out of the 64 reported abortions by the 49 women, 33 were aborted by unsafe means telling of evidence of repeat abortions. This implies that there are nearly as many unsafe abortions as there are safe ones among these women. Twenty-seven out of the 49 women have their first abortion by unsafe means; 17 of these women are 'never married' and nulliparous at the time of first abortion while 10 are mothers with at least one child at the time of abortion. Among the mothers, 4 are in a stable relationship, 3 are 'never married' at the time of first abortion, 2 are separated and 1 is a widow. Twelve of these women are under 20 years of age, 10 of them are between 20 and 24 years of age, while 5 women between 25 and 30 years of age. In contrast to the previous chapter, the most vulnerable groups of women, for example, young primigravidas who would ordinarily require delicate care, students of primary schooling, the unemployed, casual labourers, hairdressers, sex workers, women whose 'breadwinners' are subsistence farmers, residence of the Kilifi rural, peri-urban and Mombasa city, women of all religious orientation are pushed to informal settings that result in severe injuries primarily because they lack finances. Legal barriers contribute to the inequities in abortion care seeking by women of differing social status.

8.3 Informal Institutional Settings

The informal institutional settings can be categorized into i) home settings and ii) 'clinic' settings. The differences between the two settings are that in the home settings, it is the women who abort by themselves; they use oral methods, mainly herbal abortifacients and sometimes pharmaceuticals. On the other hand, 'clinic' settings are the places where women seek health services because their damaging home methods fail to work. Unskilled abortionists offer services in these 'clinics' at a fee, using intrusive or invasive methods that result in severe complications to women. However, some proprietors of unlicensed 'clinics' in the rural Kilifi are skilled

[78] see Appendix I: Characteristics of the 49 Women Participants, Tables 1a-e, 2 and 3

unlicensed abortionists operating in unsanitary conditions. The "ever mushrooming" 'clinics' are responsive to the great demands for abortion services among other health needs. Below is a discussion of each, starting with the home setting.

8.3.1 Home settings

Unsafe abortions originate within the home and in the neighbourhood. It is here that women secretly prepare and administer by mouth home-made abortifacients by themselves or with the assistance of a female social connection. The women are a repository of abortion knowledge and help each other on how to terminate. Most of the substances used by the women are either concocted from traditional herbs or pharmaceuticals normally used to cure minor ailments at home by self-prescription. Self-treatment with local herbs and pharmaceuticals for general ailments is a common practice in Kenyan households. The only difference here is that they prepare and drink the concoctions in lethal doses with an intention to discontinue pregnancy. *Binti* Salma's first abortion, was early, assisted by her knowledgeable peer, and provides an excellent illustration of what transpires in the home settings. She narrates,

> "She boiled a whole quarter of the *shubiri*,[79] left it to cool then gave me to drink. She put the rest in a bottle and I took it home. Then I drank it three times morning, at lunchtime and evening. I stayed for about three days or so and I started seeing signs because the pregnancy was two months. *Shubiri* takes long to drink because it is very bitter but once you have put it in the mouth you just feel the stomach twisting. That is when it is working. It is painful I tell you, it is very painful, it is painful. My stomach was aching, aching and that night I saw wonders. I had to go to the toilet, I felt like pushing, and when I did that, it was clots of blood. They came out. I just kept quiet. I did not say. I never had any problems as it was the first one, and it was young so it was not strong." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Primary Incomplete; Muslim; Primary incomplete; Mombasa City]

[79] Black shiny herbal gum, easily soluble in water, very bitter and popular home remedy for children's stomach problems

Early abortion (below 8 weeks gestation), by means of traditional herbal abortifacients administered at home, is a reliable, effective fertility control option to these women. That they are usually 'successful[80]' does not imply that the procedure is safe but that "it works" because early pregnancy is "not strong", meaning it may still be unstable. The *shubiri* is the most popular of the herbal abortifacients among women who are "poor" or "had little money" because it costs almost nothing. It is easily accessible at any local *duka* (a small shop) and the preparation method is simple and it is easy to administer orally. The bitterness of the abortifacient is associated with its potency. Incidentally, women who have had a series of multiple successful abortions using herbs, meaning no incomplete abortion, believe they have a "good stomach". Multiple abortions are common, and women consider themselves "lucky" because "my pregnancies come easily and get out so nicely".

The *Mkilifi* or *Muarubaini* is another popular herbal abortifacient that "works" in procuring early abortion. In the Coast Province being a malarial zone, the herbs are commonly used for household treatment of malaria fever, among other illnesses. Like the *shubiri*, these abortive herbs are widely and cheaply available in the local bushes and market places; and the women also know the recipes therefore do not always involve an abortionist, "you just pick the herbs from the bushes/forest". It is also common to find quinine drugs in every local shop. Medical providers often advise pregnant women to consult a physician before treating suspected malaria fever as anti-malaria drugs may inadvertently abort early pregnancy. The women know that an overdose of quinine is poisonous enough to kill, not just the fetus but the woman as well. Indeed, one of *Binti* Grace's abortions was spontaneous after self-treatment with over-the-counter Fansidar.[81] Other herbal abortifacients reported are passion fruit leaves and sisal-looking plants. Surprisingly, an overdose of contraceptive pills is what *Bi* Fatma used in her second abortion. In these desperate efforts the women seek workable methods within their means with consequences to their health. Clearly, when women are poor, they have limited health choices that threaten their lives.

[80] Successful abortion refers to a procedure that caused no complication and with no noticeable injuries.
[81] Fansidar is a brand name of an anti-malaria drug with a sulfur base. The quinine drugs work by creating a toxic environment in the womb unfavourable to the proper growth of the foetus hence killing and expelling it in two weeks (Personal communication with Prof. J Moodley, 2006, the Nelson Mandela Medical School, University of KwaZulu-Natal).

Furthermore, late abortion (second trimester or mid-trimester) poses "difficulties" to women when performed in home settings. In her second abortion (20 weeks) in the home setting, *Binti* Salma "tried very many things" assisted by the same friend, some of which are,

> "…these razors; you take like ten razors or so, boil until the writings fade away, the razors become pale, then you put the water aside to cool, you sieve it, then drink the water and it goes to slice just like the razor does. That one also helps but it did not work, it refused. Then my girlfriend told me "let's go and cut these *magamba ya Muarubaini*"[82]/ (bark of the Neem tree). Yes, those ones. I boiled until it (solution) was very black. That one is superior to *shubiri*. That is what I drank. I stayed for about a week because it has to grind/shred. Then I started seeing the waste and the slime and clots and clots of blood. I aborted in the toilet. It was like three in the morning. I stayed and never said anything." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

Binti Salma's description of how the abortifacients work to grind or shred the fetus as the "razor" does is more a belief in magic than science and exemplifies a case of 'Sympathetic Magic Frazer'.[83] Although *Binti* Salma aborted, she suffered permanent injuries from these concoctions, in particular the metallic salts; these consequences are discussed later in this chapter. She kept the abortion affair secret from her family members.

A continuum in obtaining services driven by affordability and size of pregnancy is observed. Delay to seek abortion due to lack of finances, confusion, or conflict in decision-making is common among these women. After methods in the home settings "did not work", some women resort to 'clinics' for 'professional' help. Most 'clinic' abortions, except the herbalists', result in severe complications. These may be due to the advanced gestation size of pregnancy, unskilled

[82] Mombasa women call the Neem tree *Muarubaini* while Kilifi women refer to the same as *Mkilifi*. The bitter dark solution derived from boiled *Muarubaini* leaves, roots or barks (*magamba*) is a traditional anti-malaria remedy used in most households. Women reported the barks as the most potent for aborting advanced pregnancy.

[83] Sympathetic Magic Frazer, with its laws of Similarity and Contact "assumes that things act on each other at a distance through secret sympathy, the impulse being transmitted from one to the other by means of what we may conceive as a kind of ether, to explain how things can physically affect each other through a space which appears to be empty". (http://www.bartleby.com/196/5.html)

abortionists, unsanitary and intrusive instruments used in the operation, and certainly the squalid conditions. 'Clinic' settings, provider competence, and type of procedures used are analyzed below from the viewpoint of the women.

8.3.2 'Clinic' settings

Given the above discussion, it is not surprising that most women seeking abortions in 'clinics' are in mid-trimester pregnancy. The informal private health sector plays a major role in meeting the high demand for abortion by the Kilifi and Mombasa women studied. Sometimes women refer to these settings as 'hospital'. For example, *Bi* Rehema, a mother of two children, describes the rural 'clinic' in Kilifi that she and her husband visited "at night" as "hospital" but it is actually a room turned "clinic" situated in the provider's house. A similar "clinic" setting is aptly described by *Bi* Anita as "…that is somebody's house". Although these 'clinics' are located in the neighbourhoods, they are inconspicuous. They are either a room in the provider's house or rented premises at local shopping centres. Some settings are in obscure houses and difficult to locate even at close quarters. For example, when *Binti* Amina, who had seven years schooling wanted to abort her first pregnancy, her sister made enquiries from neighbours who directed them to a 'clinic'. On reaching it, they still had difficulties identifying the place and still had to "enquire somewhere around". The 'clinics' range from those furnished with ordinary beds, "not like hospital beds" to others with adjustable hospital bed with gynaecological clamps to hold the legs apart, and to still others that had none. In the latter setting, the procedure is performed as the woman lay on a mat spread on the earthen floor.

Some women travel from Mombasa city to recommended 'clinics' in the Kilifi rural, for example Mazeras located a few kilometres away from the Mombasa city along the Mombasa-Nairobi highway. Public transport is frequent and relatively affordable. The Kilifi rural is home to the popular *Mkunga*[84] (traditional birth attendant- TBA). At her home there is a special separate mud hut that is the delivery room, and where she, sometimes, performs abortions. Then there is the *Mganga wa kienyeji* (traditional medicine-man/herbalist) situated in the Kilifi district and

[84] *Mkunga* (singular.) is Kiswahili for traditional birth attendant [TBA] (plural: *Wakunga*). The government recognized that about 90 per cent women in the rural areas rely on TBA's for deliveries. They were trained by MOH so that they could offer quality services to mothers. Later this initiative was stopped as there was evidence of increased still births suspected to be due to the persistent old practices such as '*kukanda*' [abdominal massage or trauma] by TBAs.

Mombasa city. The *Mganga*'s settings are the usual mud house, fenced all round and with a pit latrine by the far corner of the house which serves to dispose of aborted products. In Kilifi, the *Mganga* grows treatment herbs in his compound.

The type of instruments and other paraphernalia observable on the 'doctor's' table, and the poor sanitary settings are characteristic of the 'clinic' setting. *Binti* Amina notes, "On getting inside, true he has instruments for abortion; you could just tell abortion service is provided in that place." Similarly, *Binti* Tina, the 20 year old who had completed college but was "doing nothing" expresses concerns about the 'clinic' she visited,

> "It wasn't a clean place. It was evident that the 'doctor' did that kind of work because there was a bed, scissors, cotton wool, syringes and the needle. I didn't know whether they had been boiled. I didn't know who else they had been used on. It's a bad place as a whole, it's dangerous. They can easily infect you with diseases. They [Ministry of Health] should close down those clinics." [*Binti* Tina: 1 unsafe abortion; never married; nulliparous; Secondary complete; Mombasa City]

Women describe the repulsive unsanitary clinical settings and the typical paraphernalia, underscoring their discomfort and reservations about the services offered and the dangers posed to their health. The "needle" used to puncture the cervix is characteristic of the invasive metal instruments used by the *Mkunga* and the wide range of 'doctors'. Other instruments used by the 'doctor' are "a mere stick that was sharpened for the purpose" in conjunction with a dilator "just like the one used in hospital"; a "urine pipe" or what some women describe as a "yellow rubber-tube" (catheter).[85] "Cleanliness condition is very poor, even the instruments are not very clean", said *Bi* Pendo, a married woman with four children, dissatisfied with the hygiene of the rural 'clinic' in Kilifi. However, sanitation concerns are not a priority to women at that time, what the women want is the pregnancy removed. "To be honest, I never bothered to see whether she

[85] The catheter method is effective since a catheter is too large and too invasive an object to be ignored by a pregnant uterus (Schoen, 2005:144).

cleaned the tools or not, all I wanted was for the pregnancy to be aborted, my concern was the abortion," says *Binti* Farida, who had just completed primary schooling (Standard 8).

These 'clinics' operate illegally as they are not registered by the Ministry of Health (MoH) because they do not meet the minimum medical standards. Indeed, the Medical Officer of Health (MOH), Mombasa District Hospital (MDH), decries the ever mushrooming of these 'clinics' that pose a public health threat. Every so often, the District Public Health Officers (DPHOs) conduct 'crack-down' missions on these 'clinics'. This is because the 'clinics' not only pose a threat to women's lives but also create overload for public health facilities, overstretching the already constrained resources, as some of the survivors of unsafe abortion seek treatment for complications. It can be argued that these "clinics" exploit the large unmet demand for abortion care (as they do other health needs) to a fast growing population that the government fails to satisfy. Unfortunately, most of these women are at the prime of their reproductive potential, are nulliparous yet these unskilled providers with their crude facilities and horrendous procedures form the women's first gynaecological experience threatening their future fertility. Others are parous in unstable or stable relationships and their disability or mortality has great ramifications to their existing children, families and communities at large. Adeokun (1991) alludes to the selectivity of service by socio-economic status with the more vulnerable cases being pushed to these least effective settings with high risk of morbidity or death.

These unattractive settings offer a range of relatively cheaper fees for women with financial constraints. Among the informal providers, the *Mkunga* and the *Mganga wa kienyeji* (traditional medicine-man/herbalist) settings are cheapest charging about KES 1,000 while the 'doctors' tend to charge more (almost the same as clinics offering safe abortion). When one considers the additional cost of post-abortion care, the total monetary cost of unsafe abortion is already far too expensive for the women and the government, not to mention the disability costs. Most women associate these settings, dingy rooms and unsanitary instruments, with the incompetence of the provider and understand the risks they undertake but they are desperate and lack choice.

8.4 Technical Competence

Providers include paramedical practitioners such as the traditional medicine-man or herbalist (*Mganga wa kienyeji*), the traditional birth attendant – TBA (*Mkunga*), and 'doctors'. The 'doctors' are specifically people who have ever worked in health care facilities: They include mortuary attendants, clinical officers and other cadres of retired hospital staff Most of these 'doctors' have no abortion skills (a few are skilled but unlicensed) but continue to handle the largest number of women seeking abortion and offer a wide range of health services. Although both male and female 'doctors' are mentioned in the fieldwork, more male 'doctors' perform abortions than female ones. Women in need of abortion services have no trouble accessing the providers whom they hear about from friends and neighbours. They rely on what others have to say or their own experiences to assess the skill of the abortionist. Some abortionists are 'popular' while others are not. A provider is highly rated if s/he "washes you clean" meaning with no complications. *Bi* Zena explains the hallmark of a competent abortionist,

> "I chose to go there because a friend talked highly of that place. If you go there he washes you and you walk away clean. Because there are some (service providers), who give you the service and then you take complications home. Could be he washes you but does not remove everything so you get problems. Therefore, so and so can do it" [*Bi* Zena: 1 unsafe abortion; separated; 2 children; no education; Kilifi Rural]

Women's intuition, encounters, and observations provide good descriptions of the diverse competences of providers. One may therefore distinguish between the abortionists masquerading as 'doctors' and qualified medical practitioners. Certainly, qualified medical practitioners, whose actual cadre we cannot establish beyond the women's descriptions, did provide unsafe abortions, because they are not skilled in safe abortion care. Similarly, some skilled abortionists are unregistered and their settings unsanitary. *Binti* Amina's description of the 'doctor' sums up most women's observations:

> "My sister was saying that it is a doctor. Mmmh doctor, doctor, but the doctor was not in a hospital, it was a house; and he was not wearing a white coat. She enquired somewhere around; I do not know from whom and she was told 'that one there inside is the doctor'." [*Binti* Amina: 2 unsafe abortions; never married; nulliparous; primary incomplete; Mombasa City]

Women associate the setting and medical garb with the technical competence of the provider. The fact that the 'doctor' operated in "a house" and did not wear the characteristic "white coat" made *Binti* Amina suspicious of his competence, hence her expression "Mmmh doctor, doctor". Traditional herbalists are popular due to the perceived effectiveness of their herbs and are regarded as "expert" by clients. The herbalists are men with good knowledge of herbal abortive methods. The different technologies used by diverse providers are discussed below.

8.5 Technological Aspects

Physical methods that are intrusive or invasive involving insertion of an instrument through the cervix into the uterus to trigger the abortion process are characteristic of the *Mkunga* and the 'doctors'. Although some 'doctors' are competent in the use of the MVA technology, they operate in unlicensed 'clinics' under unsanitary conditions, sometimes resulting in complications. Similarly, although some abortionists are qualified and registered medical providers, they are unskilled in abortion procedures; they still use the D&C, a procedure not recommended by the WHO. The traditional herbalist utilizes herbal abortifacients, oral and intra-vaginal. The gestation size of the pregnancy is often late first trimester (12 weeks) or in the second trimester. The subsections that follow discuss women's descriptions of these techniques, starting with the physical methods.

8.5.1 Physical methods

The terms women repeatedly use to describe the invasive procedures are telling in themselves of the pain and damage inflicted by the instruments. These concepts are -*chokora* (poke around), *anakuchokora huko chini* (pokes around you down there) and *akadungadunga* (pierce severely).

The “crude” process of piercing severely involves breaking tissue and causing other injuries, temporary and permanent. The women brave and suffer these horrendous procedures.

> “I spread my legs, then he took that long crotchet needle, the one for knitting sweaters, he poked inside there (*akachokora huko ndani*). After poking, I thought the abortion would follow. Instead, he placed a pad and told me I would bleed little by little first for some time.” [*Binti* Amina: 2 unsafe abortions; never married; nulliparous; Primary incomplete; Mombasa City]

By use of the metal instrument, the “long crotchet needle”, the ‘doctor’ punctured, bruised and severally poked (-*chokora*) at the cervix to trigger the abortion process. The physical technique is traumatic and women describe it as a nightmare. The D&C method is reportedly used for mid-trimester abortion by some medical providers unskilled in abortion procedures. After administration of labour-inducing drugs to facilitate expulsion, *Binti* Francie, single and nulliparous, vividly illustrates the trauma of the D&C,

> “I was told to spread my legs while my legs and hands were tied, you are positioned like this (demonstrates with hands) the bed is lifted, and he is seeing everything of yours up there and he poked inside there (‘akachokora huko ndani’). For the first time I have never had a male doctor peep through my private parts under there, you see it is a bad act, so I was saying, “now what is this”, tears were just coming out and I was just crying.” [*Binti* Francie: 3 safe abortions; never married; nulliparous; Mombasa City]

In her description, the entire procedure is “an inhumane act” due to the gynaecological positioning, excessive handling and intrusion into the woman’s private parts by a male doctor. The contractions are painful, lasting from morning to evening, causing “psychological torture, the pain; you feel you should just die”. She told the doctor, "You should just kill me, instead of keeping me here with this pain, just kill me I do not want to live.” The motivation to abort fortified her “because now I am in school what will I do, I wanted to finish my Form Four exams, haa!” She had complications that were treated at the provincial hospital. Women endure

indignity, pain, and risk to their health for the sake of adhering to social norms and values, without which they will not successfully complete school, pursue career or be marriageable.

The MVA technique is skillfully used by some providers in the rural Kilifi and women are satisfied that they did not "take home complications", "you leave all the dirt there", "no problems". Nonetheless, a few women report excessive bleeding "swam in blood". *Bi* Anita, married and parous, describes the procedure as follows,

> "(laughing) He took a thing I don't know what it was, he inserted I could feel the thing (tool) rotating inside at the same time he pressed where the foetus was. Then it started coming out. It came out completely, then he said 'get up' I got up." [*Bi* Anita: 1 unsafe abortion; married; 4 children; no education; Kilifi Rural]

On the contrary, mid-trimester abortions require different methods and are problematic. Abortion is triggered at the 'clinic' then contractions and expulsion take place in the night at the woman's home. By contrast to the single women, the married women have no concern about taking complications home. While *Bi* Anita's pregnancy was 12 weeks gestation size, *Bi* Rehema's was above 12 weeks because she was not aware she had conceived while on the Depo.

> "He just told me to lie on the bed and I did, then he went on with his business until he finished, I did not know what he was doing. Then we came back home and at around two in the morning the pains started. They were like labour pains, and then it aborted. I had no problem." [*Bi* Rehema: 1 unsafe abortion; married; 2 children; Secondary education; Kilifi Rural]

Notably, except for *Bi* Pendo who had infections due to the squalid conditions, no other complications or excessive pain are reported by the Kilifi Rural women. Thus, used by a skilled provider, the MVA technique reduces the risk of complications to women in low resource settings. This has implications for training of all providers in the use of the MVA technology. Analgesics and other drug types that I could only guess to be labour-inducing are given to some women.

Invasive techniques, in the form of the crotchet needle, are also utilised by the *Mkunga* who is business-like and skilled in her trade. She explains the procedure, seeks women's consent, and provides them with a *leso* (sarong) to wrap around the body after undressing. As the women lay in a "delivery position" on the sack placed on the earthen floor, the *Mkunga* "applies coconut oil[86] on" the genitalia and pubic area. She strictly cautions the women to stay composed while she firmly holds the crochet needle in her hand and inserts it through the vagina to perforate the cervix. Bi Farida narrates,

> ""You are the one with the problem so you'll have to be still". She put in her hand and you know for her she really puts it in because she is used to that job of deliveries, which is her trade. As she poked, I felt 'chwi', then she said, "I have finished". She told me to put on cotton wool before leaving because it may start bleeding on the way." [*Binti* Farida: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Generally, the single women are surprised and disturbed that they must risk "taking complications home"; providers say it will "bleed little by little first for some time" but offer no in-patient services after the triggering procedure. They are ready for the next client and unsympathetic of women's concerns: that the incomplete abortion exposes their secret health seeking to oblivious family members. Informal settings are characterized by a lack of effective linkages to referral system for prompt treatments of complications important in reducing severity of morbidity (Adeokun, 1991). Follow-up for after abortion care is up to the client. This is in contrast to the professional care provided in most formal institutions. It marks a potential point of intervention in a restricted legal environment. Awareness creation and support is necessary so that, rather than go home, women can proceed to the closest health facility for timely management of complications. It is possible that the women are not aware they could obtain emergency post abortion treatment at any Health Centre (HC) free of charge. However, it is also possible that the women fear being reprimanded by medical staff or legal repercussions, as happens in some cases. I did not directly inquire about women's awareness of post abortion care

[86] Coconut oil was commonly used at the Coast for body massage and skin moisturiser among other uses.

offered in public health facilities; I recommend this for further study. The complications suffered and their management, are discussed after the following section which illustrates the techniques used by the herbalists.

8 .5.2 Herbal abortifacients

Herbal potions characterised by their extreme bitterness, are potent abortifacients with minimal or no observable injuries or poisoning. Two methods of herbal administration are distinguishable: oral and intra-vaginal. The herbalist (*Mganga*) administers both techniques. Herbal abortifacients are commonly used by women of diverse cultures in Africa (Rasch and Kipingili, 2009; Hess, 2007; Jackson et al., 2011; Dahlback et al., 2007). Some herbalists also handle mid-trimester abortions, and claim to terminate viable fetuses (beyond 22 weeks). "Women come with those problems at eight months and I try. They drop their thing here nicely and bury right here", an herbalist boasted of his expertise to *Bi* Fatma who aborted a 16 weeks pregnancy. Unlike the 'doctor' and the *Mkunga*, the herbalist has pre-abortion conditions that women have to consent to. He requires that women get "a urine test" done to ascertain pregnancy and size. The test is done at a specific formal institution that he trusts, the well-known Mkomani Clinic, and he pays for it. The *Mganga* is keen to demonstrate to women his expertise by using the correct type and concentration of herbal abortifacient. Incorrect treatment would lead to clients claiming his herbs are ineffective, doubt his herbal proficiency, and consequently ruin his professional reputation. For the same reason, the '*Mganga*'s' other condition is that women drink the herbal potion "here in my house" and "not outside of this premise" until the abortion completes in the toilet the same day. Therefore, women did not take complications home. The desperate women agree to these conditions and "it became like a secret between us".

After drinking the herbal concoction from "a bottle the size of a beer bottle" (500ml), *Bi* Fatma the widowed mother writhed in pain for hours. It was not clear exactly what "different types of herbs" constituted the herbal potion but *Bi* Fatma suspects that *shubiri* is among these, "because it was a very bitter concoction". In all her determination to abort for the first time, she could not finish drinking the bitter potion, she laughs as she recalls,

> "I drank but I tell you (laughing) I could not finish because it is bitter! That thing is bitter!! After half an hour I started feeling stomach pangs; the stomach was 'cutting, cutting, cutting' ('tumbo likawa linanikata, likakata, likakata')." [*Bi* Fatma: 2 abortions; widow; 2 children; Secondary incomplete; Muslim; Kilifi Peri-urban]

The process started in the morning and by evening, other than blood spotting, and excruciating pain, nothing had "come out" so she requested to go home. The following day, the "thing" came out seemingly with no complications, she sighs with relief as she says,

> "That thing ('hicho kitu') came out nicely without any problem and it just came out completely at once, hwaa! Then the whole day I was just bleeding with 'dirt' ('uchafu') coming out. By evening it (bleeding) was little and normal." [*Bi* Fatma: 2 abortions; widow; 2 children; Secondary incomplete; Muslim; Kilifi Peri-urban]

It is interesting that the women sometimes refer to the fetus as a "thing" thus depersonifying the pregnancy. Intra-vaginal methods are also applied by some herbalists or "a man who pretends to be an *Mganga wa kienyeji* (herbalist)" as *Binti* Amina, single and nulliparous, refers to the Kilifi herbalist in disgust. He was famous for growing some special abortive plants in his compound. The traditional herbalist exploits women's desperate state by coitally abusing them. The abuse is perhaps propelled by the common notion that single women seeking abortion are prostitutes, free for all. He penetrates them intra-vaginally by means of his unprotected penis under the pretext of administering abortive herbal medicine. This male method is reportedly used in Malawi (Jackson et al., 2011). The abortion was *Binti* Amina's second in the same year, the first having been procured at the 'doctor's' 'clinic'; she describes the herbal procedure,

> ""Before I give you this *dawa* (medicine) I have to apply some on my *mdudu*/penis and insert it inside of you. As I push that *dawa* (medicine) inside the pregnancy will abort." I saw him apply something for sure and then he entered me and pushed; it was something that he (the *Mganga*) did *chap chap* (quick)" [*Binti*

Amina: 2 unsafe abortions; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Certainly, there are options in aiding vaginal insertion of medicines one of which is to advise the woman to self-insert. It is noteworthy that women seeking abortions are in a very vulnerable position and did not complain about abuse and malpractice. Confidentiality is critical for both the woman and the abusive abortionist. The woman is ready to compromise to ensure the pregnancy is ended to spare her the social disgrace and insufferable permanent economic burden that comes with unintended childbearing. At that point, there is no turning back! He then prescribed a "big bottle (*jichupa*)" full of herbal concoction and which *Binti* Amina was to take "in doses until the bottle was empty after which "that thing" would come out." The 'dirt' poured out in the toilet as *Binti* Amina endured the abdominal pains at home. Although the *Mganga* had told *Binti* Amina to return, she was afraid to go back noting the sexual abuse. In retrospect, *Binti* Amina says, "sometimes it is not worth it", referring to what women go through to procure an abortion. The matter remains a source of much trauma particularly because *Binti* Amina "worried that maybe I contracted some disease because he entered me just like that without any protection." However, she never sought post exposure prophylaxis, perhaps for lack of awareness. Besides the trauma of the bitter herbs, contractual pains and coital abuse by some Herbalists, the women report no visible complications thereafter. This is in contrast to the physical methods applied by the 'Doctor' and the 'Mkunga' where women suffer severe consequences that are the subject of the discussion that follows.

8.6 Complications of Unsafe Abortion: "It aborted but with many problems"

Some women report complications that range from medium to long-term disabilities and comprises sporadic bleeding; irregular excessive bleeding, during periods, weight loss and paleness (perhaps anaemia), backache, chronic uterine pain; infections [reproductive tract infection (RTI) and pelvic inflammatory disease (PID)], delay in conceiving in the future (temporary infecundity); ectopic pregnancy, miscarriages, premature pregnancies; cervical incompetence and ulcers. Hospital studies using medical records in Kenya and elsewhere in

Africa have repeatedly reported these medical sequelae (APHRC et al., 2013; Biddlecom, 2008; Gebreselassie et al., 2005; Okonofua et al., 2005; Rasch and Lyaruu, 2005; Gallo et al., 2004 Oye-Adeniran et al., 2004; Rasch et al., 2000b; Rogo et al. 1999b; Mundigo & Indriso, 1999; Population Council, 1996). Bourne (1972) explains that retained products of conception in the cavity of the uterus may give rise to further complications, haemorrhage,[87] and sepsis. The first sign of sepsis is usually the onset of pain. The voices of women survivors impress on the suffering they experience. A case in point is that of *Bi* Pendo, the married parous woman resident in the rural Kilifi; she presented with septicaemia two days after abortion. She had excessive pain, haemorrhage, lost consciousness for two days and she felt "My life was like gone, it was God's miracle that I came back (regained consciousness)". If the sepsis becomes severe or if it remains untreated, it may jeopardise the future fertility of the woman. Sadly, some women knowingly or unknowingly live with morbidities because, in their view, the abortions are 'successful'. It is later when they are married and desire pregnancy that they realize they suffer infertility caused by cervical incompetence. Given their young age, the unmarried women of primary schooling suffer disproportionate morbidities.

Women who abort using herbal abortifacients either in household settings or at the *Mganga wa kienyeji* (traditional medicine man/herbalist) report the least suffering while those who abort by means of intrusive or invasive procedures employed by the 'doctor' and the *Mkunga* suffer the most severe complications. Clearly, oral herbal methods when pregnancy is "still small" (early abortion about 8 weeks) "works" and reduces the risk of complications. A similar finding is reported in Tanzania by Rasch and Kipingili (2009). Late herbal abortion at the traditional herbalist's takes comparatively longer to abort than early abortion but it "works" too, with minimal complications. By contrast, late gestation, intrusive methods combined with the incompetence of the 'Doctor' and the *Mkunga* are great risk factors to women's health. Hence, even when unsafe procedures are used, early herbal abortion, commonly practiced in home settings, or applied by the Herbalist, prevents or reduces complications and injuries to women.

The most frequently reported complications of unsafe abortions are incomplete abortion characterised by excruciating pain and distress during and after the procedure. "The coming out

[87] Haemorrhage is excessive bleeding following soon after the operation.

was the problem" and sometimes, and unfortunately so, it meant women returned to the incompetent abortionist for a repeat of the procedure. For example after three days of indescribable pain and screaming *Binti* Amina's sister panicked and took her back to the "doctor". The 'doctor' repeated the same procedure, "He poked and poked (*akachokora, akachokora*)[88] but it did not abort still." The 'doctor' also applied general instead of local anesthesia to perform the 'surgery'. Certainly, the support, persistence, and assertiveness of *Binti* Amina's sister saved her life because the 'doctor' finally made transfer arrangements with a contact at a formal private hospital. The transfer to a formal institution for post-abortion evacuation is the most commendable aspect of this appalling process. Medical providers operating illegal clinics are likely to transfer a patient to a formal institution when complications arise (Adeokun, 1991); although in this case it took the aggressiveness of the client's sister. *Binti* Amina recounts her agony,

> "That thing stayed for another three days. It was bleeding very little by little. My sister kept on going to tell that doctor that my condition was still bad. On the third day that doctor, that one who says he is a doctor, came and took me to (name of hospital) by 'matatu' (public vehicle)." [*Binti* Amina: 2 unsafe abortions; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Delayed management of complications aggravates injuries and further endangers the woman's survival. Sometimes it took more than a week of extreme pain and looming danger before the products of conception are expelled. Prof. Moodley[89] explained that this is not unusual particularly for a primigravida, as pregnancy in the final stage of first trimester could be firm, making it difficult to abort. After that, it took another one or two weeks of suffering with complications before treatment. For some women with complications, access to emergency treatment is even more complex.

"It aborted but with a lot of problems, terrible stomach pains" that subject women to indignity and embarrassment. On some occasions, this happens in front of the very people from whom the

[88] A Ki-Swahili term literally meaning forceful 'disturbance' or 'causing turbulence'; it was often used to describe the risky procedure where a pointed instrument is inserted in the cervix to induce abortion.
[89] Personal communication with Prof. J Moodley, 2006

women had wanted to hide the matter for fear of hurting them. Unusual "clots of blood" in the toilet or falling involuntarily in front of clueless family members, exposes the women's abortion secret. *Binti* Farida's sister was "very harsh" demanding an explanation from her after the blood clots she found in the toilet. Sometimes it was mothers, who, in shock, witness their daughters' complications right before them putting women in an awkward position, recalls *Binti* Saida,

> "I felt like passing urine then something fell and my mother saw it because it was a big fleshy clot of blood. My mother was shocked and asked whether I was aborting a pregnancy!" [*Binti* Saida: 1 unsafe abortion; never married; nulliparous; Secondary student; Muslim; Mombasa City]

In other cases, the women smell awful, and risked anemia, gangrene and death,

> "I was emitting another stench you just could not sit with me like this. You feel general ache in the whole body and you think you got malaria; the bleeding is excessive and inside it is like you are rotting, is that not death?" [*Binti* Chao: 1 unsafe abortion; never married; 1 child; Secondary complete; Mombasa City]

Binti Chao an unmarried woman with one child continues to aptly describe extraordinary pains that accompanied the abortion and that alerted her mother of her health seeking secret,

> "It aborted but the way I felt... aaah...I got pains! You feel I mean pains, pains. I mean it is another kind of pain surely, even the pain of giving birth is more bearable, of course, I gave birth... that pain is not like the labour pains at delivery." [*Binti* Chao: 1 unsafe abortion; never married; 1 child; Secondary complete; Mombasa City]

The unbearable pains prompting inevitable screams draw the attention of family members.

> "I had a lot of pain that is what exposed me at home. People got to know that "this one has aborted" and were surprised, eeeh! I had to say who was responsible (for

> the pregnancy). "Oooh we warned you that one is a Christian" (said her family)." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Primary complete; Muslim; Mombasa City]

Interestingly, the concern of *Binti* Salma's family is not the abortion; but the fact that the man responsible failed to meet their approval. Her family rushed her to a private hospital for management of complications. It is family members or volunteer neighbours who respond to the distress calls of women and rush them to hospital for emergency treatment.

8.7 Participants' Perspectives on Unsafe Abortion

This study inquired of informants' perspectives on abortion and the law briefly highlighted here to provide basis for and reinforce conclusions and recommendations. This and the previous chapter provides evidence that women rely on private abortion services, formal and informal, because the legal position bar public health facilities from offering abortion services. In general, medical providers in public and private health facilities interviewed as key informants have supportive views regarding safe abortion services and lament about women's sufferings in unsafe procedures.

In particular, Nurses Zainab and Mwende, who played a double role as key informants and as women with shared abortion experiences, view the issue as 'insiders'. As medical providers and from their emic abortion experiences, they know that no law can stop abortion because "when a woman is determined to have an abortion, she will do it". Nurses Zainab and Mwende, both senior nurses in Mombasa City and Kilifi district respectively, confirm that demand for abortion is high: "Patients come to request for abortion". They argue that it makes little rational sense for health providers to watch as women go for unsafe procedures then wait to treat survivors,

> "A patient will come to me and tell me she has a pregnancy and she wants an abortion so I tell her I cannot provide the service. She then goes out there, inserts a crotchet and induces the abortion then comes to me with complications and I

> open up to 'wash' her. So even if I do not do it, someone else will do it because she has decided she does not want to keep the pregnancy. That's it." [Nurse Mwende: 1 safe abortion; never married; 1 child; Tertiary education; Kilifi Peri-urban]

Unfortunately, the "someone else" is often the unskilled provider. Nurse Mwende is a medical provider in the Kilifi District Hospital and operates her private clinic off-hours. The women confirm these sentiments as evidenced in *Binti* Grace's displeasure with providers, who refuse to offer services or interrogate women,

> "This business of being asked, "Why are you doing that (abortion), do you know you will be charged (legal prosecution)?" You get afraid already so you say, "fine I'll keep it", but once you are out of that place (clinic/hospital) you start thinking of ways of doing it 'kienyeji' (traditionally)." [*Binti* Grace: 2 safe abortions; married; 1 child; Secondary complete; Mombasa City]

The District Public Health Officers (DPHOs) and District Public Health Nurses (DPHN) and some private medical practitioners interviewed endorse the above views. Theirs is a medical and public health perspective of abortion. They too argued from their experience that a woman seeking abortion services when turned away will risk her life in the hands of unskilled providers and return for treatment of complications if they survive; it is these very complications that cause the overload in gynaecological ward admissions. Public health officials are informed professionals with a commitment to promote preventive public health initiatives that reduce workload for hospitals and enhance population health as the district Public Health Officer (DPHO) explains.

Nurse Zainab emphatically dismisses the current abortion law as archaic and compromises women's health,

> "You know those are laws, which were made long time ago, they belong to that century, OK. So it is high time they (meaning the government) should wake up

> and realize to be declared healthy, a person is supposed to be psychologically fit. Actually the whole pregnancy is tormenting, by the way this person is not healthy. I think the law is too harsh on people who want to procure an abortion. But to me, believe it or not people still procure abortion." [Nurse Zainab: Mombasa City; divorced; 1 child; 1 safe abortion]

Nurse Zainab's profound assessment is based on the definition of health which states thus, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1958). The above perspectives are telling that there exist medical providers in private and public institutions who feel strongly against unsafe abortion and supportive of change towards the provision of safe abortion care.

8.8 Summary and Conclusion

Unlike safe abortion, unsafe abortion threatens the health and lives of the most vulnerable Kenyan women. These are the poor women, those residing in the rural areas, the young people below 20 years of age, and the nulliparous and parous, students in primary and secondary education. The womenfolk are a repository of abortion knowledge. Early abortion, below 8 weeks gestation performed in home settings by use of herbal abortifacients has fewer complications. We recommend laboratory research on these herbal abortifacients to better understand their potential hazards or benefits for the women. In contrast, abortion by use of physical methods, by the *Mkunga* and the 'doctor' results in severe injuries to women. The *Mkunga* and the 'doctor' often handle abortions at the end of first trimester and those in second trimester. It is women with these severe complications that sometimes by chance find themselves at formal private and public health facilities seeking post abortion care discussed in the chapter that follows.

CHAPTER NINE

9.0 COMPREHENSIVE POST ABORTION CARE[90]

9.1 Introduction

This chapter addresses how the survivors of unsafe abortion seek comprehensive post abortion care[91] (cPAC). The cPAC is an intervention model for countering the health consequences and reducing the cycle of repeat abortions. The model is three-pronged consisting of i) management of complications or post abortion care (PAC); ii) post abortion family planning (PAFP) counselling; and iii) linkages to other reproductive health services. Given the restrictions on abortion care, it is after undergoing the suffering of unsafe procedures described in the previous chapter that survivors of unsafe abortion are expected to seek treatment services in formal health facilities. Although the cPAC is ideally present in all provincial, district and sub-district hospitals, findings of this study reveal lower level public facilities lack the capacity to offer these services despite the great demand. For example, in the year 2012 alone an estimated 119, 912 Kenyan women were treated for induced abortion complication at public and private health facilities (APHRC et al., 2013). In this study, the voices of the survivors give the human face to the numbers reported in hospital studies and the many more who seek no after abortion care; the narrations reveal the sufferings experienced before final arrival at formal or informal health facilities, on arrival at the formal health facilities and those who fail to seek care. These emic experiences lack in abortion literature in Kenya where there exists a dearth of information on the cPAC. The final section of this chapter is the Figure 9-1 that captures the conclusions arising from this and the previous chapter.

[90] 3rd International Conference on Family Planning: Full Access, Full Choice, Addis Ababa, Ethiopia 12-15 November, 2013. "Since I have not given birth yet, I cannot use", exploring the dilemma of family planning among post abortive women in Mombasa City and the Kilifi district, Kenya. Submitted for publication in *International Journal of Gynecology & Obstetrics 31st March 2014*

[91] Adeokun's 1991 framework lacks the cPAC model. The cPAC was introduced in Kenya in 1996 following the ICPD, Cairo, 1994.

9.2 Management of Complications

Emergency treatment of complications is the first of three components of the comprehensive post abortion care (cPAC) package aimed at reducing maternal morbidity and mortality. The MVA method is both used for abortion as discussed in the previous chapters and for the evacuation of products of conception in incomplete abortion. Misoprostol, a more efficient and efficacious medical treatment, is similarly recommended but is rarely used in Kenya due to challenges of drug registration (Osur et al., 2013) and associated abortion restrictions. Notably, few women in this study seek treatment for complications of unsafe abortion at the formal health facilities. Firstly, most perceive their abortions to be 'successful'. Indeed, early herbal abortion is often "easy" and 'successful'. "That thing came out without me going to the hospital" some women say. This corroborates the World Health Organization's estimates that 50% to 90% of women do not have medical complications after unsafe abortion (WHO, 1998). Also, that most women survive these procedures without suffering ill effects (Schoen, 2005: 145).

Secondly, at the home setting, sometimes women use a traditional herbal variety (locally known as *dawa za shango*) for a week to "wash" the womb or "clear the dirty blood" and firming the stomach after abortion, delivery and menstruation. These women avoid substantial costs of treating preventable "problems" of unsafe abortion. *Dawa za shango* is also popular for general stomach ailments. *Bi* Fatma details how it works:

> "The stomach pained and pained and pained. I just started using herbal medicine, *dawa za shango* (she gave me a sample later) there and then. It's good because it pulls out that dirt. After drinking that my stomach went down, and cleared of all the dirty blood completely and it dried after about one week. I was told to drink it persistently. So I kept on going to this woman (*Mganga*/traditional herbalist) to get the *mafungo* (bundles). I used eight bundles. You can also just pick the herbs from the bushes/forest." [*Bi* Fatma: 2 abortions; widow; 2 children; Secondary incomplete; Muslim; Kilifi Peri-urban]

Thirdly, complications are in rare occasions satisfactorily managed by the same abortionist. For instance, *Bi* Pendo's 'doctor' abortionist, a trained Clinical Officer, operating an unlicensed clinic in the rural Kilifi also treated her of attendant complications. *Bi* Pendo recalls,

> "My husband went for the doctor and he came. I just hear that is what he did because I was unconscious. It was very serious so I had to be carried to his (doctor's) place. He infused me with IV fluids. The stomach was swollen so then he washed me." [*Bi* Pendo: 1 unsafe abortion; married; 4 children; Primary incomplete; Kilifi Rural]

The term "wash" refers to the evacuation procedure that 'clean' all products of conception, which women refer to as 'dirt' from the "womb" or the "stomach". Half as many women, who seek treatment for abortion-related complications in formal health facilities, go to private hospitals as they do to public health facilities. Private hospitals are preferred by family members largely due to fear of the public hospital given the legal restrictions on abortion. Fear of stigma and retribution by health providers (in public hospitals) also make single women and their families reticent to seek gynaecological services. It is likely that confidentiality, ensured in private more than in public hospitals, is also a major consideration for families. Conclusively, that only a small proportion of women who undergo unsafe abortion come to a public health facility for treatment, we accept as reasonable. Indeed, they are the "tip of the iceberg" as often expressed in abortion literature in Kenya (Solo et al., 1999).

Nonetheless, some parents take their daughters to the Coast provincial referral hospital (CPGH). From study observation and information from the providers, it is common for Muslim parents to bring their daughters to the ward for after abortion care and introduce a male family member as husband to camouflage complications as due to a miscarriage. Given the difficulty of recruiting study participants for such a sensitive topic, only four women with reported induced abortions were from a public health facility, the CPGH. The CPGH handles high caseloads of induced abortion complications in the region relative to other levels of public health facilities. From this study finding, the major reason is because the CPGH has sophisticated equipment and specialized medical staff to handle the severe cases that often present.

Often some women find themselves at the CPGH courtesy of neighbours or volunteer as in the typical case presented below. The women do not live with their parents at the time of abortion. They may live on their own working as casual labourers, or they may cohabit with a male partner who deserts them, or they may live with a cousin/sister who is also a casual labourer. They try to keep secret their contacts to avoid follow up and do not inform their parents.

It is by sheer chance that parents, sisters or neighbours discover the women's need for after abortion care. Thus, after abortion care at formal health facilities is seriously delayed further aggravating injuries and threatening women's lives. Notably from the previous chapter, it is mostly second trimester abortions, performed one to two weeks previously using intrusive methods, handled by 'doctors' and the *Mkunga* that result in severe complications that end up in formal health facilities for treatment. In their categorization of severity of unsafe abortion complications treated at formal health facilities, APHRC et al. (2013) also found delayed health care seeking was associated with severity of complications. All the women treated for abortion-related complications at the CPGH are of primary schooling, nulliparous and most lack family support.

9.2.1 The long journey to the Coast Provincial General Hospital (CPGH)

A typical emergency scene is depicted in *Binti* Rukia's experience. She was alone in the one rental room in a 'Swahili[92]' house where she lived with her boyfriend before he deserted her after he learned about the pregnancy. She cut and pulled out the catheter inserted more than one week previously by the 'doctor'. Her neighbours responded to her distress screams and the long journey to the CPGH begins, as she narrates:

> "I came here (CPGH) on Thursday night. I was bleeding excessively. I had severe abdominal pains and my stomach was swelling. I was so dizzy, when I try to get

[92] The 'Swahili' are the coastal inhabitants most of them descending from a mix of Arab blood. The 'Swahili' house design is a common feature particularly in Mombasa district. The traditional design of the house has one main front entrance with several rooms inside, say four rooms on either side of the passage. The different tenants rent the single rooms while sharing a common kitchen, bathroom, store, an open patio space at the rear of the house, and two rear exit doors. There is limited privacy for occupants.

> up I fall. The neighbors helped me. They are the ones who carried me at night. Aaah! I was crying. It was around 10.00 P.M or so when a woman neighbour called others to assist. It forced them to take a wheelbarrow and take me to hospital because I was unconscious." [*Binti* Rukia: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Most women present like Binti Rukia in a precarious health condition, with incomplete abortion, infection, "excessive bleeding", "severe abdominal pains", "stomach swelling" and loss of consciousness. These severe conditions fit with those found in the national abortion study on Incidence and Complications of Unsafe Abortion (APHRC et al., 2013) where 77% of women who presented for post abortion care were classified as having moderately severe and severe complications. The neighbours and well-wishers who by some chance witness the women's distress contribute resources within their means to rush them to hospital in order to save their lives. The journey to *Makadara*[93] (read CPGH) for emergency treatment is long and difficult with incremental delays at each stage that further threaten the women's survival; it involves using the wheelbarrow to get women to the main road where a vehicle is likely to be found; public service vehicles or volunteer motorists rush the women to the nearest private clinic; well-wishers donate money to assist in treatment fees; often the clinic 'doctor' refers the patient to the CPGH; this sometimes means that neighbours must hire a "taxi" (cab) to transport her to the casualty department of the provincial referral hospital. *Binti* Rukia continues her recount of the treatment at the CPGH,

> ". I was given an injection, while down there at emergency (casualty department) and then they put me on this (showing the needle at her arm) drip. Then I was put somewhere aside and slept and later they said I can be brought up here (in the gynaecological ward). Now I am better since they 'washed' me, but the day before yesterday, mmh! (sighs deeply)." [Binti Rukia: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

[93] The CPGH is commonly referred to as Makadara by the residents.

Although formal private health facilities are located relatively close to the homes of most women, some lack the capacity to manage complication or are afraid to seek treatment there for legal reasons and therefore women are referred to the CPGH. It is usual for women to go through three referrals before receiving proper treatment. The women first visit the nearest private hospital which often fails to treat them and refers the patients to the next public hospital, that is, the Mombasa district hospital (then in Port-Reitz) where they receive the basic MVA services. However, given that most women delay seeking care most complications require more sophisticated medical treatment by highly skilled medical professionals often not available at the district hospitals. Their deteriorating condition, such as acute septicaemiae, demands further referral to the CPGH which has medical scans for specialised treatment by specialised doctors. The case of *Binti* Kamene admitted in the gynaecological ward of the CPGH for one and half months perfectly fits this scenario; she underwent a partial hysterectomy, excision of part of her digestive system, four days of coma post theatre, and blood infusion. These referrals contribute to further treatment delays, aggravating infection.

Additionally, the admission process at the CPGH is not as efficient as an emergency of this nature calls for and the casualty department staff members are not friendly to women. On arrival at the emergency casualty department, it takes a long time before women receive attention, despite the fact that they are in pain, feverish and some in an unconscious state It is not unusual to get a harsh response from the medical staff such as, "do not try to rush us, we know our work; if you think we are delaying you, just carry her and go away with her", when those escorting the women patients plead for medical attention. Similarly, women patients who cry uncontrollably because they are in inexplicable pain, are sometimes mocked by the medical staff as follows, "we know a patient does not cry, a patient keeps quiet that's how we know you are sick, but if you cry then we know you are not sick".

Further delays in treatment are noted even after clinical observations are done at the casualty department. After admission to the gynaecological ward, the women are instructed to pay KES 1,

500 to facilitate booking[94] for "washing" the same day or the following day depending on arrival time. I met *Binti* Riziki for interview, four days post admission and she had not been "washed". "The problem was money", she explains. Thus, we observed many cases of deferred treatment sometimes for longer than 5 days. How the unmarried women, rushed to hospital by chance by volunteers, are expected to pay treatment fees upfront remains unclear. Furthermore, detaining women only works to inflate the hospital fees for the woman and creates an artificial bed shortage arising from unnecessary bed occupancy in the already constrained health system.

By contrast, same-day emergency services are possible at the Coast Provincial General Hospital (CPGH) if one has money. Evacuation, analgesics, antibiotics, haematinics and nutrition information are services the CPGH offers. For example, after *Binti* Salma's second abortion resulted in complications, her parents rushed her to the CPGH.

> "I was taken to Coast (read CPGH) for 'washing'. I stayed only that one day, I was taken in the morning, I was 'washed' and stayed until evening and was discharged. We paid about three thousand, (at *Makadara*) the day's admission, 'washing', the drugs, and the services there. After that I was eating healthy nutritious foods, fruits, plenty of fruits until I felt better." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

According to the hospital administration, upfront payment is enforced because when women are treated pending payment they escape from the ward to evade payment. Occasionally, the hospital administration reviews and waivers what they consider genuine cases of women who stay for very long due to inability to pay. Compounding the deferred treatment is the shortage of medical staff and the cost sharing health policies that apply in public health facilities, such that most of the patient care is the responsibility of the family. Certainly, the CPGH being the highest referral hospital in the province offers costly services compared to the Health Centres (HCs) which are meant to offer free post abortion care but most of them lack the capacity. Delayed treatment

[94] The MVA booking charges are highest at the CPGH (KES 1,500) followed by the district hospital (KES 750) while the services are expected to be free of charge at the Health Centres (HCs). However, HCs do not yet offer MVA services because they lack capacity (mainly MVA-trained personnel).

seeking aggravates injuries making it necessary for specialized treatment at the CPGH which is financially costly to the Ministry of Health and to the women and their health. Increasing the capacity of HCs and private clinics to offer prompt post abortion care and friendly affordable services close to the women is an important recommendation from this study.

Aloneness is characteristic of unmarried women while married women are always under the supportive care of a spouse or close relatives who intensively monitor their progress. Family support at the hospital is a necessity to help augment services not provided by the hospital staff such as meeting basic requirements. Special diets, fruits and other basic personal effects such as cotton wool, sanitary pads, washbasins, toiletries, and so on are purchased[95] by the family. The patient purchases all drugs prescribed, such as haematinics,[96] antibiotics and analgesics, from the hospital's pharmacy. This presents a challenge for most unmarried women because they are typically brought to the hospital by volunteer neighbours or friends who often never returned to follow up on their progress perhaps to avoid further responsibility. Rarely is family members of the unmarried women involved because their stay in hospital remains secret.

The CPGH is well furnished for provision of competent cPAC services as discussions with one of the clinical officers performing the MVA and our study observations reveal. The sanitized MVA room has tools sterilized with high-level disinfectant for the MVA kit; and autoclaving for the metallic tools. The providers use a "no-touch technique", wear gloves and surgical gowns during the operation, and waste is disposed in incinerators. Ideally it is expected that the woman spend at least 24 hours during emergency treatment services, according to the Sister-in-Charge of the ward. Most middle level providers i.e. nurses, clinical officers, medical officers (at the CPGH), and consultants are skilled in cPAC. However, use of analgesia for pain management is rare. The screams of women alert all in the ward that an MVA procedure is in progress. Fortunately after the procedure, the women felt immediate pain relief and excessive bleeding ceases. Although the women are in general content with the treatment services, they complain about the poor sanitation at the gynaecological ward, and say, "The toilets and the place for

[95] Within the hospital was a canteen and outside the hospital gate are plenty of vendors.
[96] Haematinics are a must prescription for all women with abortion because the Coast province is a malaria zone, so women are often anaemic at admission. Blood transfusion is necessary in some cases. (interview with the nurse-in-charge of the gynaecological ward)

throwing waste are not good according to expected hospital standards". Certainly, the quality of post abortion care for these women is in question.

Overall, where cPAC services are available, surveys have repeatedly cited poor quality post abortion care services leading to low utilisation (Gebreselassie et al., 2005; Gallo et al., 2004; Oye-Adeniran et al., 2004a). While the study findings concur with this position it also possible that the restrictive legal environment that heightens stigma is a contributing factor to the low utilization of services evidenced in this study.

9.3 Post Abortion Family Planning Counselling

The Ministry of Health Guidelines emphasizes the importance of contraceptive counselling as the second component of post abortion care after management of complications to prevent repeat unwanted pregnancy. Providers should inform women that they could get pregnant within the first ten days after an abortion (Ministry of Health, 1997:64). Where contraceptives are not available, the provider should offer counselling followed by referrals for the commodities. Instructions on hygiene and nutrition care, how much bleeding to expect, recognizing complications and seeking help for them should be very clear to women before they leave the health facility (WHO, 2003a). Quality post abortion care is severely compromised by lack of family planning counseling in the study area.

In reality family planning counselling services in these gynaecological wards are not part of the routine care in the public health facilities that we visited during the course of the study. For example, during our four months stay at the CPGH, we never once witnessed a single family planning counseling session taking place in the gynaecological ward. However, evidence exists of an appropriately furnished room labeled "Family Planning Counseling" and on the inside walls the familiar blue poster describing the various family planning methods, but no supplies available. This is the room we used for contraceptive counseling for study participants and in which we held most of the interviews. Quality comprehensive post abortion care (cPAC) is severely compromised by lack of family planning counselling in the study area. This increases

women's risk to repeat unwanted pregnancy, unsafe abortion and sustain the high maternal morbidity and mortality.

Much as the medical staffs have the skills and willingness to do so, shortage of medical staff and competing health demands in the ward make provision of family planning counseling services a less urgent task, they explain. This is in sharp contrast to the high acceptability rate expressed by providers in favour of additional responsibilities created by providing post-abortion counselling for family planning services in the ward-by-ward staff model during the feasibility study by Solo et al., (1999:23). It goes to show that sustainability of cPAC services must address other challenging factors such as understaffing in public health facilities. The high demand for information on family planning among married patients in the ward remains unmet. Most of them were requesting participation in the study with the assumption that it is a family planning education session. Additionally, some providers are opposed to use of contraceptives by unmarried women as discussed in Chapter Seven of this document.

Furthermore, PAFP remains a dream because most women who have unsafe abortions do not seek treatment in formal health facilities. A number have their complications seen to in informal settings while most others consider their abortions 'successful', or they learn to live with minor injuries. Contraceptive counseling attempt by informal providers is evident among married women in the rural Kilifi but difficulties in accessing commodities pose a major barrier. Moreover, the informal providers are incompetent in contraceptive counseling therefore misconceptions are evident in the information given. For example, *Bi* Zena, the separated woman, has this information from her informal abortionist,

> "[R]ight now do not go see a man until three months are over because you have to stay until you know your dates for menses before using contraceptives otherwise you will definitely get another pregnancy." [*Bi* Zena: 1 unsafe abortion; separated; 2 children; no education; Kilifi Rural]

Repeat unplanned pregnancy and a cycle of unsafe abortion or unwanted childbearing are common due to these misconceptions and lack of effective post-abortion contraception as shown in the excerpt below:

Box 9-1: Excerpt from *Bi* Anita's transcript

Binti Tina: It came out completely, then he said get up I got up (kid singing).
I: And did he give you any counseling after the abortion or a follow up/return date?
Binti Tina: (kid singing). No. He said "go look for another method (start family planning) otherwise you will get another pregnancy". And I didn't take long, I got this one (baby in her hands).
I: How long did you take to get another pregnancy?

Bi Anita's Transcript/Kilifi rural/190605/CK1

Highly motivated women make efforts to obtain modern contraceptives, sometimes immediately, and at other times they delay. These women have at least one child. For example, although *Bi* Rehema did take up family planning "after it had aborted" she took a long time. She said, "I stayed and stayed until I had regained my health." She had the Norplant fixed at a private hospital, switching from the Depo that had failed her. It is not clear why *Bi* Rehema preferred the private hospital over the public (KDH) since they are located on the same highway (the Mombasa-Malindi). However, it is notable that her pregnancy had been confirmed at the KDH before proceeding to a private 'clinic' for the abortion.

Besides the few cases mentioned above, post-abortion contraceptive has very low uptake, a worrying fact considering efforts to reduce repeat abortions, the burden of morbidity among the women population, overloaded gynaecological wards, and overstretched limited resources. (Nulliparous) women's reasons for disinterest in post-abortion family planning are their

overwhelming concern about their current and future fertility.[97] *Binti* Rukia expresses concerns and sometimes the confusion typical of unmarried women,

> "Yes, I have heard of family planning methods but I have never used them. Some people tell me those 'dawas' (medicines) are not good some say they are good. So I do not know. Some people say they mess up the uterus and you will not give birth again. Since I have not given birth yet, I cannot use. Even now, I would not like to use them." [*Binti* Rukia: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Injuries resulting from unsafe abortion constitute a major barrier to family planning use by the nulliparous women because of fertility concerns with implications for gender. Some are "even afraid to think of family planning" because they desperately need gynaecological treatment to restore their fertility capacities after marriage. *Binti* Farida summarizes the views of women, who suffer reproductive injuries resulting in strong aversion to contraceptive use after marriage when fertility is desirable,

> "I have never used family planning. Even now, I do not use 'dawa', (family planning) but I have not conceived. They will give me more problems because my stomach has a problem. I use nothing at all. I am even afraid to think of family planning because I have stayed and stayed without conceiving." [*Binti* Farida: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

Furthermore, the side-effects of family planning methods are intolerable to these women. *Binti* Salma tells of her attempts to use contraceptives after marriage,

> "First, I used pills, they did not suit me, and they were making my heart beat very fast and have heavy bleeding. Therefore, I had to change. Now I am using the

[97] Refer to Chapter Six

injection. The injection is making me suffer…." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

Clearly, women using contraceptives for the first time need follow-up support while their bodies adjust. Generally, post-abortion contraceptive counseling in public and private health facilities remains a big challenge. Equally important is the contraceptive counseling gap for women who do not seek treatment following unsafe abortion. The after abortion care should be sensitive to the diverse needs of women after an abortion. For example, the priority for women who have suffered uterine injuries is not contraceptives but specialised reproductive correction. This constitutes the third component of post-abortion care, namely, the links to other reproductive health services.

9.4 Links to other Reproductive Health Services

Links to other reproductive health services that can improve women's overall health is the third component of post-abortion care. However, we found that the links are absent despite the great need to help counter the reported long-term consequences of unsafe abortion, infertility and chronic abdominal pain. A few women who experience multiple permanent injuries or pelvic inflammatory infections (PID) require further specialized gynaecological treatment, follow-up and linking with other appropriate departments to manage their conditions. Infertility is the greatest health concern. Bearing children is the primary goal of marriage therefore, childlessness or sub-infertility is a big threat to marriage and attracts social stigma in most parts of Africa (Sewpaul, 1996). The fertility of women measures their social worth and gives them "joy" and fulfillment in their family and society. Women desperately need expert support to achieve their fertility desires after marriage. Hence, *Binti* Salma appeals,

"The government should do everything to help a woman to give birth even if it is one child, at least, so that she can also have joy/happiness in her house. You know the joy of this world is to have a baby. If you have no baby, you do not look nice

before people." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

Women use expressions such as "distressed", "disturbed", and "preoccupies my mind", "it really eats at me", "regret" to explain their devastation for taking long to conceive after marriage. "After getting married I took very long to conceive, two years". It was worse because "people were talking", "questioning", "You are not giving birth what is wrong with you?" In South Africa too, marriage is associated with childbearing therefore family and public concerns are triggered when a bride fails to exhibit signs of pregnancy within what is regarded a reasonable time (Preston-Whyte, 1999: 149). *Binti* Francie, the unmarried woman who had three abortions with financial support from her fiancé, her current husband says,

> "But I am so disturbed, I tell you that thing disturbs me so much and I am really regretting, I regret (Louisa-my name). I know people are also talking and saying "how come she has not given birth? [98]" even his parents they are so bad I tell you; I always cry, I cry…. In fact today I have comforted myself. Aaai!" [*Binti* Francie: 1 unsafe abortion; 2 safe abortions; never married; nulliparous; Secondary complete; Mombasa City]

Women's regret about their abortion is related to their ability to conceive later in marriage. Cervical incompetence[99] is widely reported among the women with multiple abortions. Most women describe it using the expression *kizazi kiko chini* (literally meaning "uterus is low or dropped uterus"). Later in marriage when women exhibit habitual miscarriages, they are informed by their medical providers that "the uterus is loose because I have aborted pregnancies a lot". A damaged cervix is liable to infection and more importantly leads to spontaneous late abortion or premature delivery in subsequent pregnancies. Recurrent abortion may occur as a direct result or indirectly due to damage to the upper part of the canal of the cervix. Caesarean section may be likely because of previous scarring of the uterus (Bourne, 1972). Several studies

[98] Two years later, I met *Binti* Francie all smiles carrying her baby girl.
[99] A condition of overstretched cervix often associated with previous dilatation of the cervix for uterine curettage or suction aspiration.

have indicated a strong association between a history of abortion and infertility, as well as ectopic pregnancy (Mitra et al., 1997; AbouZahr and Ahman, 1998).

Infecundity results in social misery later in marriage when women desire pregnancy. *Binti* Salma and *Binti* Farida desire children in their marriages but are habitual miscarriers due to cervical incompetence. Pregnancy "was flowing out (*ilikuja ikamwaika*)". The characteristic manifestations include "those signs of blood starting to flow out again heavily" and perhaps what they describe as "dirty blood". Carrying pregnancy to full-term is a delicate task that requires "bed rest" or "light duties". Delivery is reported as pre-term, "problematic" (obstructed labour), and "low birth weight". These factors are associated with increased likelihood of neo-natal and infant mortality (KNBS and ICF Macro, 2010). Besides, these women's productivity is compromised. The women are anxious to know about their reproductive condition, *Binti* Farida laments,

> "I want another baby at least, but when? I would like to ask about my condition now. I have stayed for so long without conceiving and my periods delay in coming. I can stay for two months without seeing my periods and then I see my stomach swelling and is full and then I feel signs of pregnancy, breasts get full very nicely; then I realize later it is not pregnancy; and then I get the periods again, and they flow for even two weeks, very heavily, and it is not the normal red, it's like the color of liver, dirty blood mmmh." [*Binti* Farida: 1 unsafe abortion; never married; nulliparous; Primary incomplete; Muslim; Mombasa City]

The women posed these difficult questions to the interviewers, who in turn referred them to the counseling nurse in the study. The women poignantly and painfully reflect on and are haunted by the abortion instrument used by the *Mkunga* "the woman with the long crotchet needle" and related their injuries to this procedure. These women are denied a healthy entry into their reproductive phase and marriage.

> "Until now, I have problems. I am married I am staying well but now my uterus only, it disturbs me. The uterus (*uzazi*) pains me. I cannot sit for too long, I cannot cope with much work; sometimes even making love with my husband is difficult because the uterus pains, do you see, and now I cannot tell at home (marital home) because he does not know that I did that business. 'Kizazi'! (my uterus!), (she cried)." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

The women are in daily tears in their marriages and do not have a satisfying sex life. A healthy "uterus" ('kizazi') and enjoyment of conjugal relations is the sexual and reproductive right of every woman. Yet, abdominal "pain" is endemic among women. Infection may give rise to pelvic pain and discomfort and may spread to the fallopian tubes causing infertility (Bourne, 1972). That women learn to cope with most of their suffering for the sake of confidentiality may hamper efforts to seek appropriate treatment. In the hospital obstetric wards and in households we met many women with unanswered questions regarding their miscarriages and other pregnancy related problems. Women are in need of this consultation/information but lack someone to provide it. They are in desperate need of specialist examination and treatment in a "good hospital", which in Kenya means a private hospital. They can neither afford the cost nor share these concerns with their husbands. Husbands are often responsible for health decision-making since they have control of the financial resources. Fortunately, as married women, they can freely visit the hospital for gynaecological examinations; however, special attention is not forthcoming at the public facility. The fact and irony of the matter is that the CPGH, which most Mombasa City women attend, has the most qualified gynaecologists and medical equipment, yet these issues receive little attention.

Among the unmarried women, the psychosocial sequelae or trauma results from the totality of the steps involved in the route to abortion, and the unsafe procedures. The traumatic entry is the women's first gynaecological experience, they are under excessive trauma and distress caused by the clandestine nature of the risky procedures, suffer the anxiety of incomplete abortion, endure prolonged excruciating 'stomach pains' in silence, the loneliness, secrecy, humiliation or indignity and abuse, including sexual harassment, and the uncertainty of survival and fertility.

Note that the trauma is cummulative from the time single women discover pregnancy, through the decision-making process, the horrendous procedure and its consequences. Trauma is greatest among nulliparous women who suffer infertility after marriage and least among women with at least one child before abortion. As *Binti* Chao notes, "Those who get disturbed in the mind are those without children." The distress is also great among women whose abortions are more recent, such as those admitted at the CPGH. The anguish expressed by the women may also be explained by the ethical malpractice perpetrated by providers. Anguish is evident in women's voices, the repetition and emphasis of some words, the facial expressions and sometimes, emotional breakdown as women narrate their experiences. The pain leads most unmarried nulliparous women to declare that they would carry a repeat pregnancy to delivery, "it is better to give birth", they say.

In a study of women's perspective of induced abortion and subsequent pregnancy outcome among Chinese women in focus group sessions, moving descriptions of personal psychic trauma experienced by some women, were astonishing. Fear led to some women opting to carry the next unwanted pregnancy to term to avoid the pain of another abortion procedure while others had subsequent anxiety towards coitus (Zhou Wei-jin et al., 1999). *Bi* Zainab, a professional nurse, acknowledged that abortion "is not a very good feeling actually. Nevertheless, with time and maybe, OK, talking with some friends you get encouraged." Talking about their experience in the interview is admittedly therapeutic to the majority of women.

Bourne (1972) says there is very little known about the psychological ill effects of abortion and fully concurs that such ill effects, however, do have to be weighed against those of allowing a pregnancy to continue. A 1990 and 2008 review by the American Psychological Association (APA) concluded that "severe negative reactions (after abortion) are rare and in line with those following other normal life stresses" (APA, 2008). Similarly, the Johns Hopkins Bloomberg School of Public Health, 2008, concluded that the highest quality studies found few, if any, differences between women who had abortions and their comparison groups, whereas studies with the most flaws reported negative mental health consequences of abortion (Charles et al., 2008). Figure 9-1 below gives a diagrammatic summary of women's complex experiences.

9.5 Summary and Conclusion

Few women utilize comprehensive post abortion care, more so in public health facilities hence unwanted pregnancy and repeat abortions will continue to be a public health problem. The legal context of abortion negatively impacts on post abortion care seeking. Expansion in access to cPAC at lower levels of care closer to women and equipping of the same is essential to reduce treatment delays and costs. The quality of post abortion care is in question. The cPAC cannot eliminate unsafe abortion so effective implementation of the new comprehensive abortion care Standards and Guidelines is an urgent requirement in increasing access to safe abortion and reduce maternal morbidity and mortality. I recommend for further study an inquiry of women's awareness of cPAC available in public health facilities. The need to create demand for cPAC is nonetheless an important recommendation.

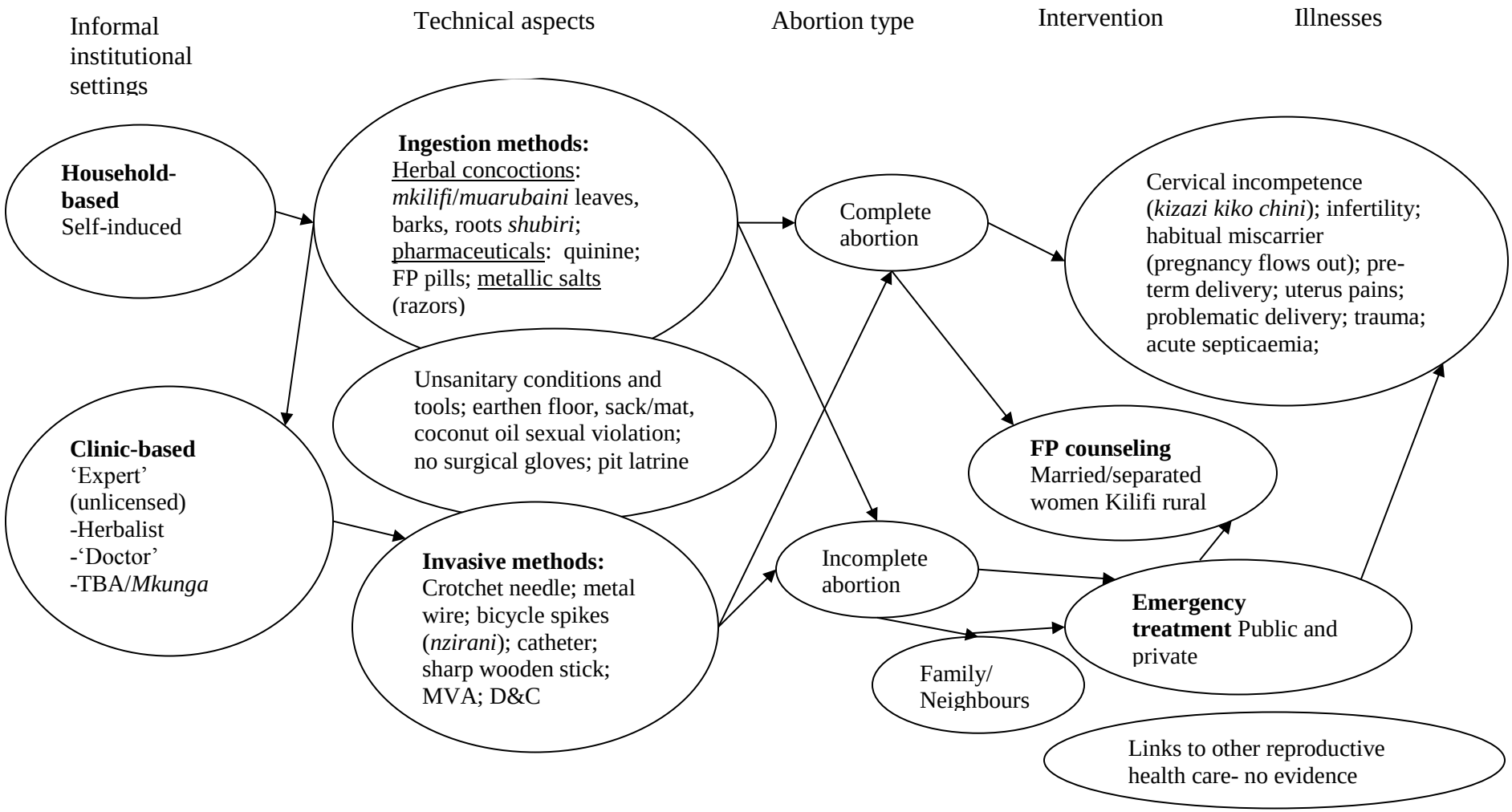


FIGURE 9-1: WOMEN'S EXPERIENCES OF UNSAFE ABORTION

CHAPTER TEN

10.0 CONCLUSIONS

10.1 Introduction

This final chapter presents a summary and assessment of the various conclusions reached at the end of each of the previous analytical chapters of this study. It further suggests recommended areas for policy, practice and future research. This study began with evidence that unsafe abortion explains the high incidence of maternal illnesses and deaths in Kenya. It was therefore assumed that understanding the totality of women's personal experiences of abortion in Mombasa City and the Kilifi district could support the development of evidence-based policies and consequent practices that could reduce incidence of maternal illness and death thereby improving the health of women in general. The term "abortion" derives from the Latin word *aboriri*, which means "to perish".

In this study, an abortion is considered to have occurred when the human fetus "perishes" before it has reached viability, that is, before a gestation period of 22 weeks or a weight of 500 grams, as recommended by the World Health Organization, (Oats and Abraham, 2005). The interest in this study is limited to induced abortion, because given the legal restrictions of abortion in Kenya they pose greater risk to women's health. The first section provides a summarised reflection of the purpose for this investigation within the social context of Mombasa City and the Kilifi district. It recapitulates the qualitative methods applied in data collection and the major study findings. In Section 10.3, the conclusions from this study are discussed and in Section 10.4 policy implications and suggestions for further research are given. Below is a summary of this investigation.

10.2 Recapitulating on the Aims of the Study

The main aim of this study was to understand the emic experiences of induced abortion among women in Mombasa City and the Kilifi district who seek abortion, both safe and unsafe, and to explore how social and legal issues impact their choices and the routes they take to obtain an abortion. The study covered a selected review of abortion literature from a global perspective in developed and developing countries, as well as those in Kenya. This emic work revealed gender inequity consistent with developing feminist theory and thus how women conceive gendered relationships is introduced in this analysis of women's narratives. Numerous studies using quantitative and qualitative approaches in major public hospitals and communities have provided sufficient evidence that links the high maternal morbidity and mortality rate in Kenya to the high prevalence of unsafe abortion. For example, researchers have demonstrated the tragic fact that one in every thirty women die as a result of complications of unsafe abortion (APHRC et al., 2013; Gebresselasie et al., 2005; NCAPD, 2005; Nzau-Ombaka, 2001; Rogo et al., 1999a; Lema et al., 1996). However, abortion literature lacks information on personal experiences among Kenyan women that would help in our understanding of this public health issue. To isolate the medical complications arising from unsafe abortions is to miss the complex and socially constructed meanings, the power relations and the social norms. This study aimed to fill this knowledge gap in order to shed light on our understanding of the phenomenon. The study responded to the following four questions:

- What social and legal issues motivate abortion-seeking behaviour of women in Mombasa City and the Kilifi district?

- How do the social and legal issues impinge on abortion-related decision making by women in Mombasa City and the Kilifi district?

- What are the experiences and consequences of abortion, particularly unsafe abortion, among women in Mombasa City and the Kilifi district?

- What policy implications do the Mombasa and Kilifi women's experiences of abortion and abortion-seeking behaviour suggest?

A constructionism epistemology, an interpretive theoretical perspective guided by women who participated in the study, grounded the research design, logic and criteria for the research process. Individual interviews with purposively selected women volunteers from urban, peri-urban and rural households took place between April and July 2005 after approval from three Ethical Review Committees. Empathetic dialogue and a non-directive form of open-ended questioning were methods uniquely honed to collect rich and "dense" descriptions. Interviewing was done by criteria-selected, well trained and experienced female field staff who used a flexible interview guide, in an environment of mutual trust. Interviewers encouraged women to guide conversations as they revealed their experiences. Using a feminist approach, I explored the contexts and interpreted 49 in-depth narratives of women's emic experiences of abortion to help answer the main question of this study: what are the experiences of induced abortion for women in Mombasa city and the Kilifi district, Kenya?

Informed consent, confidentiality, anonymity, and privacy guided the fieldwork, analysis, write up and dissemination of results. Women were fully aware and reminded of their rights to withdraw from the study during the course of the interviews, more so because it evoked many emotional reactions as women re-lived experiences that they preferred to leave to the past. A full-time counseling nurse was available for women who needed counselling services for abortion-related trauma or family planning information. Although there was initial trepidation about how to approach the women to talk about such a sensitive, secretive, moral-ridden and legally threatening event in their lives, we were pleasantly surprised by the women's willingness to open up and share their experiences.

The various stages of the analytic process included transcribing, translating transcripts, typing, preparation of text files, and theme identification by use of Nud.ist qualitative software. Writing the results was a stage of a continual process of the analysis, resulting in five chapters as follows: Chapter Five reveals profiles of the diverse contexts in which women experience abortion, Chapter Six explores the route women take to access abortion, Chapter Seven presents

emic experiences of safe abortion, while Chapter Eight presents the comparable and contrasting emic experiences of unsafe abortion, and Chapter Nine examines how, if at all, these women seek post abortion care and the quality of service rendered. A central conclusion is that women do not abort motherhood, but they do abort particular pregnancies motivated by the types of relationships they have with men. The legal status of abortion does not stop women from obtaining abortions, but creates a social status division that in turn determines who obtains and who does not obtain quality abortion care, and post abortion care.

The conclusions and recommendations of this study are not entirely new in global abortion literature but they do bring in a new perspective in abortion studies in Kenya's context. The strength of this study is in the uniqueness of the methodology used. It provides a focus on the human beings, the experiencers of abortion, and their social context to help us understand the insider view of the what, who, where, when and the how of abortion that are missing in the numbers posted in Kenya's literature. The conclusions validate existing knowledge and more importantly, women's emic experiences provide new insights in our depth understanding of the abortion issue. The voices of women help impress the sufferings and the need for urgency in addressing the problem. The following are the specific conclusions of this study.

10.3 Conclusions

Conclusively, study informants reveal that women do not abort motherhood but they do abort particular pregnancies to protect motherhood. The women abort to avoid a difficult motherhood that is likely to compromise the quality of care they envisage for their potential and existing children. This includes ensuring the best nurturing environment, material provisions, paternal and religious identity, and social legitimacy. They conceive in heterosexual relationships which are more or less stable. Some have no relationship at all with the biological father as in the cases of non-familial rape. Gendered relationships influence the abortion decision with the three impelling words, "I had to" before each layered reason the women narrate. The women did not perceive choices. Decisions to abort override religious convictions and legal restrictions because abortion is viewed as necessary and inevitable at that particular time.

The bulk of these abortions, including repeat abortions occur among women in relatively unstable relationships: these are the 'never married', the separated; the divorcees and the widows. Some 'never married' women are nulliparous while others have borne at least one child. Most are students in primary, secondary school or college, hairdressers, sex workers, and below age twenty-four years. These women are of diverse religious backgrounds that include Christian, Muslim and Traditionalist in the rural and urban areas of the study. Paradoxically, abortion stigma is less when it occurs within the confines of marriage because it is not viewed as a rejection of motherhood. Another paradox is that the abortion study interviews are therapeutic, a catharsis for the women despite delving into the secret depths of their lives and evoking their emotions.

Expressions of sexuality outside marital relationships, often evidenced by pregnancy, are often considered illicit, are frequently unstable and may also be surreptitious. To these women, resulting pregnancies are "mistakes", "the same mistake", "silly pregnancies", "an extra mouth", or "unexpected", and sometimes depersonified as "that thing". These women abort these pregnancies because they are heavily laden with stigma and illegitimacy ("haramu"), the women are branded "prostitute", "loose" "social misfit", "idiot", "cursed" and "a shame", "stupid woman", and "foolish", and their potential child illegitimate ("mwanaharamu"). The women "wash" their wombs in their reproductive struggle to stay "clean", "pure", as the pride of their parents, suitable as future wives or for marital reconciliation with their estranged husband whenever they choose to come; restore their dignity in society, "peace of mind", maintain social harmony, increase their economic opportunities in the future and provide better care for existing and future child(ren). The abortion decision is carefully and thoroughly considered involving a daunting multitude of intricate intertwined layers of extrinsic and intrinsic factors. These multiple depths of complexity defy simplistic statistical analysis instead requiring an inductive interrogation.

These women abort particular pregnancies because they want to provide the best care for their existing and potential children. The best will not happen in certain circumstances. When the economic opportunities for the 'breadwinner' deteriorate, women in stable relationships are more

likely to abort an unintended pregnancy. The 'breadwinner's' reliance on subsistence farming increases the likelihood that an unintended pregnancy will be aborted unlike when the breadwinner is in formal employment. The care of an existing baby who is still young demands more resources when an unintended pregnancy occurs failure to which their health deteriorates. The women abort to save the life of the existing child.

Similarly, the women in unstable relationships abort particular pregnancies because motherhood outside a marital relationship is a social anathema that triggers multiple serious cultural, religious, economic, and health consequences to them and their potential child with cyclic impact. Additionally, where there is religious discordance (the women are Muslim and their partners are not), the potential child is likely to suffer identity crisis. Worse still, carrying a pregnancy when they are full of hurt and hatred as a result of forced sex is not in the best interest of the potential child. In the context of this complexity, it is clear that the legal issues play no role in the reasons why these women abort. Male partners have no control over abortion decisions outside marital relations even in the few cases where they are involved in financing the procedure.

The women in stable relationships are more likely to make a consultative decision to abort with the husbands having an upper hand given their role as 'breadwinners' and health financiers. On the contrary, women in unstable relationships do not involve their male partners in their decision to abort. Often, the 'never married' women are unlikely to obtain financial support from their male partners while the 'ever married' women (separated, divorcees) are more likely to obtain financial support from their partners. Given the urban dynamics, few married women make an independent decision to abort.

Delayed care seeking increases risk of complications and aggravates injuries. Among the 'never married' nulliparous women, the decision to abort is ambivalent, shrouded with conflict and confusion, and takes long even when it is a repeat abortion or a rape pregnancy. Secrecy, the hallmark of abortion care seeking, is heightened by legal barriers and related stigma. These factors contribute to delays in care seeking with risk implications for the women. The women follow a continuum in abortion access from unsafe to safe abortion due to financial difficulties.

They first make self-attempts to abort failure to which they seek professional care because of concerns about their future fertility. Conclusively, the route to induced abortion is complex and replete with incremental delays at each stage in the process of service seeking increasing the risk for complications and implied multiple costs.

While legal barriers fail to prevent abortions they succeed in entrenching inequities in the type of abortion care accessed condemning the most vulnerable groups of women, who are the majority in Kenya, to unsafe abortion. Safe abortion in Kenya is clandestinely and exclusively available for women with finances regardless of their type of relationship with men, stable, unstable or none. Whether safe or unsafe, different women experience abortion differently. Although diverse women have safe and unsafe abortion, the nulliparous and parous, women below 24 years of age, referred to as the young people[100], students in primary and secondary school who have no access to financial resources, those with female connections/ peers that have aborted unsafely, or reside in the rural areas regardless of all religious orientation, are likely to have unsafe abortion. For these young women, unsafe abortion is their first gynaecological experience. Conversely, women who have secondary education and above, with access to financial resources, reside in the urban or peri-urban areas, with female connections/ peers that have previously safely aborted, are likely to have safe abortion.

On the one hand, there exists a competent medical staff in formal private health institutions of different levels, located in Mombasa city and the Kilifi peri-urban area who willingly, but cautiously, meet the great demand for abortion care. They mostly use simple early abortion care technology, the MVA, lauded by the women. As health professionals and as mothers with insider experience of safe abortion, they question the logic of the law in their reasoning. On the other hand, the women have a repository of knowledge on abortion and will abort regardless of safety.

> "A patient will come to me and tell me she has a pregnancy and she wants an abortion so I tell her I cannot provide the service. She then goes out there, inserts a crotchet and induces the abortion then comes to me with complications and I open up to 'wash' her. So even if I do not do it, someone else will do it because

[100] Adolescent Reproductive Health & Development Policy, 2005-2015

she has decided she does not want to keep the pregnancy. That's it." [Nurse Mwende: 1 safe abortion; never married; 1 child; Tertiary education; Kilifi Peri-urban]

Unsafe abortion is ubiquitous in homes and impossible to eliminate. Indeed, early herbal abortions (8 weeks gestation or less) performed in home settings "work" in the sense that they are 'successful'. Commonly used herbal abortifacients are the *shubiri* and the *muarubaini* because they are cheap, easily accessible and effective. They "work" with no visible complications. In late abortion (beyond 8 weeks gestation), when performed in 'clinics', herbal abortifacients also have fewer complications. Because the women delay seeking abortion care, the majority that are economically poor turn to 'clinics' when home remedies fail to work while the few with finances seek professional care. Thus, 'clinics' often handle the bulk of second trimester (more than 12 weeks gestation) abortions with enormous repercussions. The MVA technology used by a skilled provider, albeit in unsanitary conditions, reduces complications. Of the rural Kilifi women who had the procedure by the MVA assisted by a skilled provider in unsanitary conditions, only one married woman reported complications.

Late gestation, physical methods used by the *Mkunga* and the 'doctor' in unsanitary settings results in severe injuries to women that range from medium to long-term disabilities. Incomplete abortion is the most commonly occurring complication. The intrusive methods used in 'clinics' also cause trauma, pain, plus indignity to women. Some women must bear the discomfort of being handled by male providers. Confronting sexual abuse by some 'clinic' providers multiplies the risk of infections and trauma for a few vulnerable women. Survivors enter marriage with reproductive disabilities, unable to enjoy a satisfying sexual life, their dignity and social standing denied by infertility. This also undermines other government efforts aimed at improving the status of women such as the Girl Child education; achievement of the MDGs and the Kenya's Vision 2030.

Women who experience unsafe abortions usually also fail to benefit from the comprehensive post abortion care. To begin with, most survivors of unsafe abortion consider their abortions

'successful' or they fear legal repercussions and therefore do not voluntarily seek treatment. The few survivors, who arrive for treatment at public and private formal health facilities, do so by sheer chance with assistance from family or neighbours, one to three weeks after unsafe abortion. Fear of legal repercussions and stigma hampers prompt treatment seeking. Often it is women who obtain second semester abortions who present at the formal health facilities, sometimes following three referrals, with severe complications requiring sophisticated medical equipment and specialized medical staff. Some formal private health facilities refer post abortion clients because they fear potential legal implications.

At the Coast Provincial General Hospital, treatment care is further delayed for the vulnerable clients who fail to pay evacuation fees and their care at the hospital is compromised. These cumulative delays characterize treatment seeking for post abortive clients, threatening women's survival, burdening the health system's already overstretched resources, and increasing treatment costs for the women. The women who are escorted by their parents pay treatment fees on admission and treated and discharged the same day. There's a tendency for parents to disguise their daughter's complications as a miscarriage with a male relative posing as husband. Nonetheless, the formal private health institutions handle as many post abortion care patients as do the public health facilities. Families that can afford to do so prefer taking their daughters to private facilities for confidentiality. This behavior is evidence of fear of legal repercussion and stigma.

Moreover, most women receive no family planning counseling after abortion, whether safe or unsafe. Fewer still are linked to other reproductive health services, although these are the two additional components of the comprehensive post abortion care (cPAC). Furthermore, the women and their providers have negative perceptions towards contraceptive (hormonal) use for the 'never married' nulliparous women: that they threaten future fertility. Thus, whether they receive family planning counseling or not, these women lack interest in methods that threaten their social role as future wives and mothers. Discontinuation of contraceptive method within the first three months of use is more likely for the 'never married' nulliparous women than it is for

the parous. Indeed, parous women are likely to proactively seek a family planning method in a public health facility after unsafe abortion. The rural parous women in stable and unstable relationships fail to access family planning methods after unsafe abortion due to geographical challenges. These factors increase women's risk to repeat unwanted pregnancy, unwanted childbearing or unsafe abortion and to high morbidity and mortality. Moreover, some women suffer reproductive injuries from unsafe abortion that reduce their potential for motherhood making family planning methods undesirable. Infertility and lack of a satisfying sex life at the prime of their reproductive cycle have strong implications for women's place in society.

> "The government should do everything to help a woman to give birth even if it is one child, at least, so that she can also have joy/happiness in her house. You know the joy of this world is to have a baby. If you have no baby, you do not look nice before people." [*Binti* Salma: 2 unsafe abortions; never married; nulliparous; Muslim; Primary incomplete; Mombasa City]

Conclusively, different women experience abortion differently.

10.4 Policy Implications (for the study informants)

1. The women are responsible for their own decision to abort. It's a personal decision that they only can make in the best interest of their existing and potential children because they know their situation best. The decision is difficult, thoroughly considered and confidential. The women's decisions, their voices, must be respected by any law.

2. The primary motivation for abortion among the women is to protect motherhood. The 'never married' nulliparous and parous women choose temporary loss in the present for long-term gain in their future families. They want to bring up their potential children in the best social and economic environment devoid of stigma: they want to be in stable relationships with a husband/a responsible father to provide for their children; give their children legitimacy and identity, they

want to complete school, and have a career/employment so as to be best mothers for their future children, have dignified motherhood.

Government policy must make available to women in unstable relationships (for example students) the education, information and the safe means to support them to delay motherhood without compromising their future fertility until they are prepared to take on their desired role.

Similarly, parenting responsibilities motivate the married women/couples to abort. They want to provide the best care for their existing children. This will not happen if the 'breadwinner' is unemployed. *Bi* Rehema's husband, a father of two children, is emphatic about their parental role,

> We thought we should do that so that we may have enough time to prepare for another baby when we really need it. Right now I'm jobless and I don't know when I can be recalled to work. It's not good to bring children into this world for them to suffer later. [*Bi* Rehema's husband]

The Constitution of Kenya 2010[101] mandates parental responsibility for care and protection of children. The government must therefore facilitate women/couples as they attempt to achieve their primary responsibility for their families. Women find abortion an important option in planning their families and preventing the suffering of potential children. This is because access to contraceptives is problematic, especially in rural areas and thus contraceptives fail to protect women.

The women whose pregnancies result from rape want to abort to avoid unpleasant motherhood. Government policy should focus on how to support mothers so that they can achieve healthy pregnancies and become nurturing mothers. Pregnancy resulting from rape is not likely to be a healthy pregnancy and subsequent motherhood resulting from rape occurs in the context of social stigma. Therefore, abortion should be legal following rape.

[101] Section 53 subsection 1e

Women who suffer secondary infertility resulting from unsafe abortion complications appeal for priority treatment to restore their fertility. Motherhood is essential for their social status as married women.

Government policy must make motherhood easier, enjoyable and nurturing; government policy should address what the women want and need rather than what others (the public) want from them. Public health practitioners must provide early safe abortion as part of the full range of choices to prevent unwanted (and thus unsupported) births.

3. Many health care providers are also mothers and insiders to experiences of abortion. They insist that the restrictive abortion law is not supportive of healthy pregnancies:

> "You know those are laws, which were made long time ago, they belong to that century, OK. So it is high time they (meaning the government) should wake up and realize to be declared healthy, a person is supposed to be psychologically fit. Actually the whole pregnancy is tormenting, by the way this person is not healthy. I think the law is too harsh on people who want to procure an abortion." [Nurse Zainab: Mombasa City; divorced; 1 child; 1 safe abortion]

The private providers studied are emphatic that no law can eliminate abortion; hence they are willing to ensure women access to safe means for healthy motherhood.

10.5 Policy Implications for Public Health Practitioners

The foremost recommendation in this study is that safe early abortion (first trimester) must be available and accessible on demand to alleviate existing health care inequities. Modern technologies such as the MVA and medical abortion (MA) used in treatment of complications after unsafe abortion are efficacious for early abortion (safe) in poor resource settings. The MA will in addition free women from the discomfort of having male providers invade their 'privacy'

and improve confidentiality. South Africa provides an appropriate model where abortion legislation, The Act, 1996, ironed out racial inequities in access to abortion care that existed during the apartheid era.

Fortunately, the formal private providers in this study are willing to provide safe abortion care. With support, they can expand access to affordable safe abortion care to communities in rural and urban areas of the study. Increased access to safe abortion will have the effect of increased utilization of cPAC and hence reduced morbidity. Programmes must invest resources in quality cPAC to consequently reduce repeat unintended pregnancy.

Second, the progressive Constitution 2010 requires technical elaboration if it is to inform local policy and guide medical providers. The local policy must embed the diverse social conditions of motherhood; the context in which women make reproductive decisions. A similar conclusion was pointed out in the analysis of narratives of American women by Williams and Shames (2004: 822). Equally important is awareness creation among the women with regards to the current provisions of the law.

Third, public health practitioners must educate and encourage men to take responsibility for reproductive decisions; where necessary, existing laws must be enforced to compel men to support pregnancies for which they are responsible.

Fourth, ideally laws should create a demand for prompt post abortion care by informing the women of their rights to seek services regardless of perceived 'success' after use of unsafe methods. This means the government must enhance the capacity of public and private health facilities at lower levels of care to provide comprehensive PAC services as proposed in other abortion studies in Kenya (APHRC et al., 2013; Evens et al., 2013). This will help reduce reproductive morbidity that denies women their motherhood. Friendly post abortion care must seek to restore women's dignity and empower them to gain control of their sexuality.

Fifth, reproductive treatment to restore fertility should be given priority attention because of the gender implications. Post abortion counseling guidelines to address trauma after unsafe abortion

is necessary to be offered voluntarily to women alongside family planning counseling. Comprehensive post abortion care cannot eliminate unsafe abortion hence the urgent requirement in increasing access to safe abortion and reduce maternal morbidity and mortality.

Sixth, there is need for public health education on the risks of unsafe abortion methods.

10.6 Areas for Further Research

There is need for similar qualitative inquiry in other communities in Kenya in order to understand the diverse contextual issues that motivate abortion in order to embed these in local policy. In particular, abortion experiences of women living with HIV will fill an important gap left by the current study.

I recommend for further study an inquiry of women's awareness of post abortion care available in public health facilities. Related to this is the need to explore medical health staff bias against providing modern contraceptives by nulliparous women.

There is need for further investigation to better understand the urban dynamics that influence independent decision making for abortion among some married women.

It would be helpful if the Kenya Medical Research Institute (KEMRI) and the Institute of Primate Research (IPR) of the National Museums of Kenya could take up investigations of herbal abortifacients such as the *shubiri*, and the *muarubaini* (the Neem) and their role in early abortion. Scientific research in India demonstrates that the Neem tree offers great opportunities for both reversible infertility and emergency contraception without any side-effects associated with other hormonal contraceptives and chemical based gels and foams (NAS, 2006; NRDC, 2006). Resulting findings could be useful in educating women on the potential public health danger or benefits that these abortifacients may have.

My future research plans

Given the above recommendations, my future research plans are based on prevention of unintended pregnancy and post abortion care, in particular contraceptive counseling. An understanding of women's awareness of post abortion care available in public and private health facilities is important for increased utilization of services and programmatic interventions to curb unintended pregnancy and repeat of the same. I plan to explore medical health staff bias against providing modern contraceptives to nulliparous women; this will purposefully include women living with HIV infection. This will be part of my postdoctoral research in integrated sexual and reproductive health and rights for development with possible funding from the University of California San Francisco in the USA or the African population Health Research Center based in Nairobi, Kenya.

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APPENDIX I: CHARACTERISTICS OF THE 49 WOMEN PARTICIPANTS

Table 1a: Contexts of abortion for women in unstable relationships- the separated, divorcees, widowed

Name	Marital status at abortion	Age first sex	Age first marriage	Years school at abortion	Occupation at abortion	Religion/ Residence	No of children at abortion	Type of abortion	**Reasons for abortion**
Bi. Neema[r]	Separated	15	17	12	Farmer	Christian/ Rural	7 children	Unsafe	Limit births; husband irresponsible; sole burden of educating & feeding existing children; additional child a burden; farming unreliable; unemployed; separated; extra-marital pregnancy; others (brothers) will object; 'malu' costly; distressed; belonged to her marital home because her children were there; want peace
Bi. Zena[r]	Separated	14	14	0	Self-employed	Muslim/ Rural	2 children	Unsafe	Unplanned pregnancy; bad luck; extra-marital pregnancy; belonged to her marital home because her children were there.
Bi Fatma[r]	Widowed	17	17	10	Sex worker	Muslim/ Peri-urban	2 children	Unsafe (2)	Too many financial problems; unplanned pregnancy; bad luck; man responsible denies and abandons responsibility; sole breadwinner; other dependents
Nurse Zainab[u]	divorcee	28	28	>15	Nurse	Muslim/ Urban	1 child	Safe	Man responsible was her estranged husband; fear of strict religious parents and religious community disapproval; fear of ostracisation.
Bi Flora	Divorcee	15	18	7	Domestic worker	Christian/ Peri-urban	2 children	Safe	Man responsible denies and abandons responsibility; distress; slight bleeding; sole breadwinner; financial constraints; low pay additional child meant additional burden; others (sister who lived with her children upcountry) would object.

Table 1b: Contexts of abortion for women in unstable relationships- the 'never married' mothers

Name	Marital status at 1st abortion	Age first sex	Years school at abortion	Occupation at Ist abortion	Religion/	No of children at Ist abortion	Type of (1st) abortion (s)	**Reasons for abortion**
Nurse Mwende	Peri-urban	19	>15	Nurse (public hospital)	Christian	1	Safe	Unplanned pregnancy; man irresponsible she could not marry him; sole breadwinner; financial constraints; additional child a burden.
Binti Feni	Peri-urban		8	Tailor	Christian	1	Safe	Lack of pregnancy support by man responsible; cannot afford sole parental responsibility of a second child.
Binti Halima[r]	Peri-urban	14	8	Casual labourer	Muslim	1 child	Unsafe (1) Safe (3)	Baby was still young; breastfeeding; she was also too young; abandoned by family; many financial constraints; Manual labour; subsequent abortions she prefers to rely on abortion; believes she cannot use contraceptives due to her health (hypertension & diabetes) ; she's sole breadwinner; has multiple partners.
Binti Chao	Urban	17	12	Casual hotel waitress & Sex worker	Christian	1	Unsafe	Lack of pregnancy support by man responsible; Still lives with her parents; parents took burden of child care responsibilities of her first mistake so she completes school; family will not forgive a second mistake.
Binti Asha	Urban	14	7	Salonist/ (hairdresser)	Muslim	1	Unsafe	Lack of pregnancy support by man responsible; already has a child at home; she still lives with her parents; another mistake is unacceptable; parents will give her no peace; economic burden; not financially OK.

Table 1c: Contexts of abortion for women in unstable relationships- the 'never married' nulliparous (urban- Mombasa city)

Name	Age first sex	Age at interview	Years school at 1st abortion	Occupation at 1st abortion	Religion	Type of abortion(s)	**Reasons for abortion**
Binti Francie	17	23	10	Secondary student	Christian	Unsafe (1) Safe (2)	Student; religious; desire to pursue career; parents would withdraw education sponsorship; youth leader; not yet married
Binti Maria	19	27	>14	1st abortion: student 2nd abortion: Youth leader	Christian (Catholic)	Safe (2)	College student; first pregnancy result of forced sex; strict Catholic background; still economically dependent on parents; parents disapproved of relationship; youth leader at church
Binti Salma	15	24	7	Student dropped out	Muslim	Unsafe (2)	Religious discordance so parents disapproved of relationship; potential child would suffer religious identity crisis
Binti Amina	15	25	7	Primary student	Muslim	Unsafe (2)	Lack of pregnancy support by the men responsible for pregnancies; no offer of marriage.
Binti Saida	18	27	11	Secondary student	Muslim	Unsafe	Schoolgirl; Shame of pregnancy before marriage; hide from parents; it would cause problems at home
Binti Farida	14	24	8	Primary student	Muslim	Unsafe	Still living with parents; unexpected; mother harsh and strictly religious; face banishment; lack of pregnancy support by man responsible
Binti Nafisa	18	25	8	Primary student	Muslim	Unsafe	Lack of pregnancy support by man (student) responsible; unexpected; harsh father; parents of man denied her support
Binti Dora	16	26	8	Primary student	Christian	Unsafe (2)	Both were students; unprepared for parenthood; a harsh father
Binti Tina	20	30	12	'doing nothing'	Christian	Unsafe	Man responsible unemployed; no offer of pregnancy support

Cont'd: Table 1c: Contexts of abortion for women in unstable relationships- the 'never married' nulliparous (urban-Mombasa city)

Name	Age first sex	Age at interview	Years school at abortion	Occupation at 1st abortion	Religion	Type of abortion(s)	**Reasons for abortion**
Binti Linda	17	19	8	Primary student	Christian	Unsafe (2)	Lack of pregnancy support by men responsible; refused to marry her; unpreparedness for fatherhood; harsh mother; family poor
Binti Ebi	18	19	12	Secondary student	Christian	Unsafe	Lack of pregnancy support by man responsible; he was unprepared for fatherhood; she was a candidate
Binti Dina	21	30	12	'Doing nothing'	Christian	Unsafe	Discovered late that man responsible was married; no pregnancy support; her mother died; poverty at home; did not want potential child to suffer
Binti Hope	21	27	>12	College student	Christian	Safe	Found out partner had multiple relationships; man not serious for marriage; did not want potential child to suffer
Binti Wasai	16	18	10	Secondary student	Christian	Safe	Still a student; want to develop career in future; good future for her children; hide evidence from parents; they would withdraw school fees; boy responsible a student too.
Binti Elsie	18	19	12	Student	Christian	Safe	Lack of pregnancy support by man responsible; he was unprepared for fatherhood; she was a candidate; her family struggling for basics
Binti Diana	19	20	12	Secondary student	Christian	Safe	The man responsible declined to support pregnancy; she wanted to pursue career for better economic future
Binti Maimuna	14	19	8	Primary student	Muslim	Safe	Man responsible did not want pregnancy so he arranged for her abortion; she wanted marriage

Cont'd: Table 1c: Contexts of abortion for women in unstable relationships- the 'never married' nulliparous (urban- Mombasa city)

Name	Age first sex	Age at interview	Years school at abortion	Occupation at abortion	Religion	Type of abortion	**Reasons for abortion**
Binti Nina	18	20	10	Secondary student	Christian	Safe	She was a student; man responsible unprepared for fatherhood; no support in pregnancy; father died and her mother is the sole breadwinner and pays her fees; did not want to add more problems to her mother; had no ability to take care of potential child.
Binti Sofi	17	21	11	Secondary student	Christian	Safe	Unprepared to be parents; both were in Form 3; man responsible abandoned her; desire to complete school, pursue a career
Binti Zilda	18	22	12	'Doing nothing'	Christian	Safe	Unexpected; preparing to go to college pursue a career; man responsible abandoned her
Binti Jane	21	26	>12	College	Christian	Safe	Man responsible not serious in long-term relationship at the time; desire to complete college
Binti Lily	15	18	10	Secondary students (Form 2)	Christian	Unsafe	Lack of support for pregnancy by man responsible; desire to complete school and pursue a career in college; harsh mother

Table 1d: Contexts of abortion for women in unstable relationships- the 'never married' nulliparous (Kilifi rural & peri-urban)

Name	Residence	Age first sex	Age at interview	Years school at abortion	Occupation at Ist abortion	Religion/	Type of (1st) abortion	**Reasons for abortion**
Binti Mercy	Peri-urban	17	18	>12	College student	Christian	Safe	Aspiring professional career; fear parental punishment; fear disappointing parents; very religious; unprepared for motherhood; child additional burden to parents and herself; man responsible also a dependent (college student); want best for future child.
Binti Mashaka	Peri-urban	20	26	12	'Doing nothing'	Christian	Safe	Lack of pregnancy at home; poverty problems at home; additional child means more suffering for her family.
Binti Grace	Peri-urban	19	25	12	Secondary Student	Christian	Safe	Candidate Form Four; man responsible abandoned; her family poor; only chance to be in school
Binti Sandra	Rural	13	18	5	Primary student	Christian	Unsafe	Family decision (her big brother and boy's aunt); she was still young

Table 1e: Contexts of abortion for women in unstable relationships- the 'never married' nulliparous (health facility- CPGH)

Name	Age first sex	Years school at abortion	Occupation at Ist abortion	Religion/	Type of (1st) abortion	**Reasons for abortion**
Binti Rukia	15	8	'Doing nothing'	Muslim	Unsafe	Man responsible offers no support for pregnancy
Binti Riziki	18	8	Casual labour	Christian	Unsafe	Man responsible abandoned her; he cheated her he was no married; she is sole 'breadwinner' for her siblings
Binti Kamene	15	8	Casual labourer	Christian	Unsafe	Cheated by man responsible for pregnancy; he abandoned her later; no support
Binti Kadzo	17	8	'Doing nothing'	Tradition	Unsafe	Man responsible for pregnancy abandoned her; cannot support a child alone

Table 2: Contexts of abortion for women in stable relationships- the married

Name	Residence	Age first sex	Age first marriage	Years school at abortion	Occupation at time of abortion	Religion	No of children at time of abortion	Type of abortion	**Reasons for abortion**
Bi Rehema[r]	Rural	18	18	12	Self-employed	Traditional	2 children	Unsafe	Contraceptive failure (Depo); baby still young-save baby's life; risk to mother's health; husband retrenched; worsening economic conditions; does not want potential child to suffer
Bi. Anita[r]	Rural	16	18	0	Housewife	Christian	3children	Unsafe	Baby still young-save baby's life; Risk to mother's health; economic burden of raising children
Bi.Pendo[r]	Rural	19	20	8	Housewife	Christian	4 children	Unsafe	Contraceptive failure (Depo); Baby still young-save baby's life; risk to mother's health
Bi.Munira[r]	Peri-urban	14	14	6	Housewife	Muslim	5 children	Safe	Baby still young-save baby's life; risk to mother's health; high cost of rearing children
Bi Chesi[r]	Peri-urban	20	20	0	Housewife	Christian	5 children	Safe	Baby still young-save baby's life; risk to mother's health; care of other family members compromised
Bi.Nadia[u]	Urban	15	18	8	Hairdresser	Muslim	2 children	Unsafe	Limiting birth; high cost of raising children

Table 3: Contexts of abortion for women in no relationship

Name	Marital status at 1st abortion	Residence	Age first sex	Years school at abortion	Occupation at Ist abortion	Religion	No of children at Ist abortion	Type of (1st) abortion	**Reasons for abortion**
Bi.Wendi[u]	Married	Urban	22	>13	college	Christian	0	Safe	Rape by acquaintance after taking drugged drinks; mental distress
Binti Joyce	Single	Urban	22	11	Secondary student	Christian	0	Safe	Gang raped; fear of not loving potential child; full of hatred
Binti Sonia	Single	Urban	20	12	'Doing nothing'	Christian	0	Safe	Forced sex by acquaintance after taking drugged drinks unknowingly

APPENDIX II: INFORMED CONSENT FORMS

Informed Consent Form for the household individual IDI (English version)

PI: Louisa Njeri Ndunyu
Organisation: University of KwaZulu-Natal, Durban
Collaborating organization: University of Nairobi
Contact person: Dr. Elizabeth Bukusi
Sponsor: World Health Organisation

Introduction:

My name is ….. and I come from …….district. I am carrying out a research study on women's/girls' health for the University of KwaZulu-Natal, South Africa, in collaboration with the University Of Nairobi, Kenya.

I am inviting you to participate in the study, whose purpose is to understand the needs of women and girls in your/this community seeking reproductive health services with regards to care and support. Before you decide whether or not to take part in this study, I would like to explain the purpose of the study, any risks to you, what is expected of you, and what I will discuss with you. Once you understand the study, and if you verbally agree to take part, I will sign on this form as confirmation to your approval. I will also write a number on this form which I will use in the file, and not your name or that of your organisation. You may have a copy of this form to keep if you wish. **Participation in this study is voluntary**.

Statement of the study:

Purpose of the study

This study is motivated by the need to better understand the issues surrounding the choices made by women/girls as they strive to control their fertility in this community. The reason I chose you is because I am interested in your experiences concerning these matters and the relevant attitudes within your/this community.

Procedures

I shall ask you questions, which I have written down as a guide to the conversation and if you agree, I shall record the discussion on an audio-tape and take notes as well. The information will be labeled using a number and a secret code and none of your personal details will be available. The interview session may take about one hour of your time.

If you do not wish to answer any of the questions posed during the interview, you may say so and I will move on to the next question. The interview will take place in a private area of your choice near your home where no one is likely to interrupt, stare at us or eavesdrop into our conversation. The information recorded is considered confidential, and no one else except me will have access to the information documented during your interview.

Since this interview is rather in-depth it may be necessary to re-interview you more than once, especially if you do not have enough time to discuss all matters. In case of a follow-up visit, this interview is flexible and you may feel free to advise me on whether you wish to be contacted or not; your preferred venue of interview; and when and how I should contact you.

Risks and discomforts

I do understand that it is not easy to talk about certain issues related to women's/girls' health. You may also find some of the questions asked sensitive in nature and may feel embarrassed or anxious as you recall experiences you may have gone through. I can offer counseling services to help you cope with the situation if you feel you need them. Your participation will not involve any legal risks to you, your home or any other person that you may refer to during this interview.

However, I do not wish you to feel uncomfortable, and you may refuse any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Benefits of the study

By participating in this study and answering these questions, you will not receive any direct benefit. However, you may feel free to discuss any reproductive health matters that concern you. Your contribution will go a long way to help increase understanding of this community in terms of their reproductive health.

Incentives

You will not be provided any incentive to take part in the research.

If there is anything that is unclear or you need further information, I shall be delighted to provide it.
[Interviewer, ask if the respondent has any questions and provide the necessary clarifications].

Who to contact:

If you want to raise any concerns about this research study later, you can contact either the PI, Louisa Ndunyu, at cell phone number 0720 647534 or email address lndunyu@yahoo.com or Elizabeth Bukusi of University of Nairobi/Kenyatta National Hospital at office telephone number 020 720794/2714851 or at cell phone number 0720 617503 or by email ebukusi@ratn.org

If you ever have questions about your rights as a research participant you can write to Professor A.N. Guantai, Secretary, Ethical Review Committee, University of Nairobi/Kenyatta National Hospital, P.O. Box 20723, Nairobi or by email KNHplan@Ken.Healthnet.org; telephone number (254) 020 726300-9.

Certificate of consent:

I have understood that the purpose of the study is to examine the needs of women and girls in our community who require reproductive health services with regards to access to care and support. I have read the above information, or it has been read to me. I realize that it may be necessary to be interviewed on more than one occasion.

I have had the opportunity to ask questions about the study and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the study at any time without in any way affecting further medical care.

Personal Identification Number of participant _____

Date _____(dd/mm/yy)

Name of researcher _____

Date and signature of researcher _____(dd/mm/yy)

Informed Consent Form for the hospital individual IDIs (English version)[102]

PI: Louisa Njeri Ndunyu
Organisation: University of KwaZulu-Natal, Durban
Collaborating organization: University of Nairobi
Contact person: Dr. Elizabeth Bukusi
Sponsor: World Health Organisation

Introduction:

My name is ….. and I come from …….district. I am carrying out a research study on women's/girls' health for the University of KwaZulu-Natal, South Africa, in collaboration with the University of Nairobi, Kenya.

I am inviting you to participate in the study on the experiences of women and girls in your/this who have unwanted pregnancy and who later decide to terminate it. Before you decide whether or not to take part in this study, I would like to explain the purpose of the study, any risks to you, what is expected of you, and what I will discuss with you. Once you understand the study, and if you verbally agree to take part, I will sign on this form as confirmation to your approval. I will also write a number on this form which I will use in the file, and not your name or that of your organisation. You may have a copy of this form to keep if you wish. **Participation in this study is voluntary**.

Statement of the study:

Purpose of the study

The purpose of this study is to examine the needs of women and girls seeking termination of pregnancy. This is because there is need to better understand the issues surrounding the choices made by women/girls as they strive to control their fertility in this community. Specifically I am going to ask you for information about access to care and counsel, social support needs and so on.

Procedures

If you agree to join the study, I shall invite you to participate in an interview. I shall ask you questions, which I have written down as a guide to the conversation and if you agree, I shall record the discussion on an audio-tape and take notes as well. The information will be labeled using a number and a secret code and none of your personal details will be available. The interview session may take about one hour of your time.

If you do not wish to answer any of the questions posed during the interview, you may say so and I will move on to the next question. The interview will take place in the privacy of this office in this hospital, and no one else but you and I will be present. The information recorded is considered confidential, and only I will have access to the information documented during your interview.

Since this interview is rather in-depth it may be necessary to re-interview you more than once if you agree to join this study, especially if you do not have enough time to discuss all matters. In case of a follow-up visit, this interview is flexible and you may feel free to advise me on whether you wish to be contacted or not; your preferred venue for interview; and when and how I should contact you.

Risks and discomforts

[102] All original Informed Consent forms used during field work were typed on institutional letterheads for authenticity.

I do understand that it is not easy to talk about certain issues related to women's/girls' health. You may also find some of the questions asked sensitive in nature and may feel embarrassed or anxious as you recall experiences you may have gone through. I can offer counseling services to help you cope with the situation if you feel you need them. Your participation will not involve any legal risks to you, your home or any other person that you may refer to during this interview.

However, I do not wish you to feel uncomfortable, and you may refuse any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Benefits of the study

By participating in this study and answering these questions, you will not receive any direct benefit. However, you may feel free to discuss any reproductive health matters that concern you, including post-abortion care. Your contribution will go a long way to help increase understanding of this community in terms of women's and girl's reproductive health.

Incentives

You will not be provided any incentive to take part in the research.

Meetings

To facilitate our appointments, I shall either provide you with transport using our project vehicle or reimburse your travel fare depending on what you advise me. Refreshments will also be provided during the conversation.

If there is anything that is unclear or you need further information, I shall be delighted to provide it.
[Interviewer, ask if the respondent has any questions and provide the necessary clarifications].

Who to contact:

If you want to raise any concerns about this research study later, you can contact either the PI, Louisa Ndunyu, at cell phone number 0720 647534 or email address lndunyu@yahoo.com or Elizabeth Bukusi of University of Nairobi/Kenyatta National Hospital at office telephone number 020 720794/2714851 or at cell phone number 0720 617503 or by email ebukusi@ratn.org

If you ever have questions about your rights as a research participant you can write to Professor A.N. Guantai, Secretary, Ethical Review Committee, University of Nairobi/Kenyatta National Hospital, P.O. Box 20723, Nairobi or by email KNHplan@Ken.Healthnet.org; telephone number (254) 020 726300-9.

Certificate of consent:

I have understood that the purpose of the study is to examine the needs of women and girls in our community who require reproductive health services with regards to access to care and support. I have read the above information, or it has been read to me. I realize that it may be necessary to be interviewed on more than one occasion.

I have had the opportunity to ask questions about the study and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understand that I have the right to withdraw from the study at any time without in any way affecting further medical care.

Personal Identification Number of participant_____Date_____ dd/mm/yy

Name of researcher_____Date and signature of researcher _____(dd/mm/yy)

Informed Consent Form for the KII participants (English version)

PI: Louisa Njeri Ndunyu
Organisation: University of KwaZulu-Natal, Durban
Collaborating organization: University of Nairobi
Contact person: Dr. Elizabeth Bukusi
Sponsor: World Health Organisation

Introduction:

My name is ….. and I come from …….district. I am carrying out a research study on women's/girls' health for the University of KwaZulu-Natal, South Africa, in collaboration with the University of Nairobi, Kenya.

I am inviting you to participate in the study, whose purpose is to understand the needs of women and girls in your/this community seeking reproductive health services with regards to care and support. Before you decide whether or not to take part in this study, I would like to explain the purpose of the study, any risks to you, what is expected of you, and what I will discuss with you. Once you understand the study, and if you verbally agree to take part, I will sign on this form as confirmation to your approval. I will also write a number on this form which I will use in the file, and not your name or that of your organisation. You may have a copy of this form to keep if you wish.

Statement of the study:
Purpose of the study

This study is motivated by the need to better understand the issues surrounding the choices made by women/girls as they strive to control their fertility in this community. The reason I chose you is because I believe you have some important information concerning these matters and you are in a position to describe to me the relevant attitudes within your/this community.

Procedures

If you agree to join the study, I shall discuss with you questions about fertility control, which I have written down as a guide to the conversation, and, if you agree, I shall record the discussion on an audio-tape and take notes as well. Only a number will be used to label the information without reference to any of your personal details.

If you do not wish to answer any of the questions posed during the interview, you may say so and I will move on to the next question. The interview will take place in a private place of your choice where there will be no interruptions or any chance of anyone eavesdropping into our conversation. If your office can provide such an environment then it can be our venue for discussion. No one else but you and I will be present. The interview session may take about one hour of your time.

The results of this study will be shared with you through a meeting after completion of this study.

Risks and discomforts

I do understand that it is not easy to talk about certain issues related to women's/girls' health. You may also find some of the questions asked sensitive in nature and may feel embarrassed or anxious as you discuss them with me. I can offer counseling services to help you cope with the situation if you feel you need them. Your participation will not involve any legal risks to you, your institutions, your home or any other person that you may refer to during this conversation.

However, I do not wish you to feel uncomfortable, and you may refuse any question or not take part in a portion of the interview if you feel the question(s) are personal or if talking about them makes you uncomfortable.

Benefits of the study

By participating in this study and answering these questions, you will not receive any direct benefit. However, you may feel free to discuss any reproductive health matters that concern you. Your will also help increase understanding of the needs of the community in terms of women's and girl's reproductive health.

Incentives

You will not be provided any incentive to take part in the research.

If there is anything that is unclear or you need further information, I shall be delighted to provide it.
[Interviewer, ask if the respondent has any questions and provide the necessary clarifications].

Who to contact:

If you want to raise any concerns about this research study later, you can contact either the PI, Louisa Ndunyu, at cell phone number 0720 647534 or email address lndunyu@yahoo.com or Elizabeth Bukusi of University of Nairobi/Kenyatta National Hospital at office telephone number 020 720794/2714851 or at cell phone number 0720 617503 or by email ebukusi@ratn.org

If you ever have questions about your rights as a research participant you can write to Professor A.N. Guantai, Secretary, Ethical Review Committee, University of Nairobi/Kenyatta National Hospital, P.O. Box 20723, Nairobi or by email KNHplan@Ken.Healthnet.org; telephone number (254) 020 726300-9.

Certificate of consent:

I have understood that the purpose of the study is to examine the needs of women and girls in our community who require reproductive health services with regards to access to care and support. I have read the above information, or it has been read to me.

I have had the opportunity to ask questions about the study and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from the study at any time without any prejudice against me or against my institution.

Personal Identification Number of participant _____

Date _____(dd/mm/yy)

Name of researcher _____

Date and signature of researcher _____(dd/mm/yy)

APPENDIX III: INTERVIEW GUIDES

Interview Guides – IDIs (English version)

Start with informed consent (IC)

Turn on tape recorder after consent has been obtained.

1. Ice breaker:

Thank to participant for willingly volunteering to be part of the study; have small talk to warm up.

For official use only- fill in later after interview.

PROJECT NAME: Women's health study **INTERVIEW NUMBER:**
PARTICIPANT UNIQUE NUMBER:
DISTRICT: **LOCATION:** **MUNICIPAL WARD/SUB-LOCATION:**
INTERVIEW NAME: **CODE:**
DATE OF INTERVIEW: DAY/MONTH/YEAR
TIME OF INTERVIEW
VENUE OF INTERVIEW
FOLLOW-UP VISIT: Kindly let me know whether you would like me to contact you after this for a further interview: YES NO If so, when can I contact you? Date _____ How can I contact you? Preferred mode of contact: _____ What is your preferred venue of interview? Venue_____ What means of transport will you use to the venue? _____

Filter question: Have you participated in this study before.

Interview starts here:

2.	**PREGNANCY HIISTORY**	
	How old were you when you first had sexual intercourse?	
	How many times have you been pregnant?	
	Do you have any sons or daughters to whom you have given birth who are living with you?	
	How many sons live with you? How many daughters live with you?	
	Do you have any sons or daughters to who you have given birth who are alive but do not live with you?	
	How many sons are live but do not live with you? And how many daughters are alive but do not live with you?	
	Have you ever given birth to a boy or girl who was born alive but later died?	
	How many boys have died? And how many girls have died?	
	Women sometimes have pregnancies that do not result in a live born child. That is, a pregnancy can end very early, in a miscarriage or an abortion or the child can be born dead. Have you had any such pregnancy that did not result in a live birth?	
	If you have not, do you have information about someone (a friend/neighbour/family member) who has had any such pregnancy that did not result in a live birth or any general information about women's experiences with pregnancy loss in the area? (if yes), would you be willing to share with me what you know about her experience? [Interviewer once again assure respondent of anonymity]	
	In all, how many such pregnancies have there been?	
	In what year and month did this pregnancy end? (more than one, list for each)	
	How many months did the pregnancy last? (if more than one, list for each). - Tell me what happened to trigger the pregnancy loss. *Probe appropriately with the following questions as participants narrates her story*:	
	Have you ever had pregnancies that you had not planned for? *Probe*	

**In case interviewee cannot continue with the rest of the interview, interviewer request for follow-up visit. Enter details in the form provided on the front page.*

NB: Interviewer probe each pregnancy loss separately

3.	**Family planning**	
	-What do you do to avoid getting pregnant? *Probe*: -How do you obtain these methods? *What method were you using to avoid pregnancy at the time you conceived? *(**INTERVIEWER ASK PARTICIPANT WITH PREGNANCY HISTORY ONLY**) -What are the traditional beliefs about contraception in this community? - How would you describe the general attitudes of the community towards unmarried women using contraceptives?	
	How would you describe the general attitudes of the community in a situation where an unmarried woman/girl gets pregnant?	
	What sources of help exist in the community for women who do not want to keep a pregnancy?	
4.	Decision-making: **Factors leading to unsafe abortion** (**INTERVIEWER SHOULD ONLY ASK THESE QUESTIONS IF PARTICIPANT HAS REPORTED ABORTION INCIDENT**)	
	How did you come to realize you were pregnant? *Probe*	

	Tell me how you went about making the decision to terminate the pregnancy. *Probe appropriately with the following questions as respondent narrates her story*: -In what ways did your family influence your decision? Probe friends, partner, neighbours -What kind of material/financial support did they offer you (specify) -What are some of the dilemmas you experienced while making the decision? -What would you say motivated you to make the final decision to abort the pregnancy? -About how long did it take you to make that final decision? -How do you now feel about the decision you made? Why? -In your opinion, who should have the final say in decisions about keeping a pregnancy or not?	
	What do you think would have happened if you decided to continue with the pregnancy? *Pro*be	
5.	**Help-seeking behaviour and post-abortion care**	
	(**INTERVIEWER ASK THESE QUESTIONS IF PARTICIPANT HAS REPORTED ABORTION INCIDENT**)	
	When a woman/girl wants to do an abortion, how does she go about it?	
	How long ago did you abort/experience pregnancy loss?	
	From whom did you first seek medical help? *Probe* [***if from an unqualified provider follow-up the response***]:	
	-Why did you choose to go to this person/place? -Where was this person located? -How far is that from your home? -How did you get there- means of transport? -Who accompanied you?	
	How many months/weeks were your pregnancy/pregnancies? *Probe for each separately*.	
	What kind of treatment was offered?	
	How was the procedure performed? *Probe*	
	Was the treatment completed there? *Probe*	
	What were some of the complications you experienced after that, if any? *Probe* -Now tell me what you did to manage the complications that you later experienced.	
	For participants at the health facilities	
	When did you come here to seek treatment? How long did it take for you to seek treatment after experiencing complications? *Probe*. How did you decide on this facility?- public or private health facilitiy. Approximately what is the distance from your home to this facility? What kind of treatment was offered here How would you rate the cost of the entire procedure?	
	What do you know about post-abortion family planning counseling? *Probe* -What are you doing now to prevent getting another unwanted pregnancy? *Probe* -what support did you receive in use of family planning?	
	How would you rate the cost of the entire procedure?	
	How would you generally describe the hygiene or sanitation or cleanliness at the facility-tools, surroundings. *Probe*. -What is your opinion on the qualifications/skills of the provider(s) who attended to you? -How would you describe their attitudes towards you when you visited?	
	Treatment status [to be obtained from service delivery points (SDPs) records]	
	Type of complications diagnosed	
	Follow-up treatment and referrals for other reproductive treatment.	

6.	**Social, cultural, religious values and beliefs, taboos**	
	What action would you take if you found out you were pregnant and did not want the pregnancy? - What would be your family's reaction if they knew you had an abortion? -what about your partner/religious institution/school? *Probe*	
	What advise would you give a friend who had a pregnancy they do not want? *Probe*	
	How do people in your community perceive induced abortion/miscarriage/still births? *Probe*	
7.	**Legal issues**	
	Are you aware of abortion legislation in Kenya? -The laws of Kenya permit abortion only if the mother's health is in danger. How do you perceive this law? *Probe* -how in your opinion, does the existing law affect the health of women in this community? *Probe*	
	If you were to make any suggestions concerning the existing law, what would these be? *Probe*	

8. Conclusion

We are reaching the end of the discussion. Do you have anything to add before I turn off the tape?

I think it went well. Do you have any comments on how you feel about the discussion?

Thank you so much for your cooperation

NB: Please fill in your details before you leave. [Interviewer fills in information of participants who may be illiterate]

Background information of the participant

Marital status	**Type of marriage**	**Age-group**	**Schooling years**	**Occupation**	**Religion**
Marital status 1. Single 2. Married 3. Divorced 4. Widowed 5. Deserted 6. Living together 7. Other (specify)	**Type of marriage** 1. Monogamous 2. polygamous	**Age-group** 15-19* 20-24 25-29 30-34 35-39 40-44 45-49	**Schooling years/ level of education** 1. Zero 2. < 8 -Primary 3. 8 –primary comple 4. >8 <12 Secondary incomplete 5. 12 Secondary complete 6. Tertiary	**Occupation** 1. Student 2. Employed 3. Self-emplo 4. Home mak 5. Subsistenc Farmer	Religion 1. Christian 2. Muslim 3. Traditional 4. Others

* Adolescents

Interview Guide – KIIs (English version)

Start with Informed Consent (IC)

Turn on tape recorder after consent has been obtained.

1. Ice breaker:

Thank the participant for willingly volunteering to be part of the study; have small talk to warm up.

Introductions: Participant to introduce himself/herself by position of office/leadership role in the community only. No personal names.

For official use only- fill in later after interview.

PROJECT NAME: Women's health study **INTERVIEW NUMBER:**
PARTICIPANT UNIQUE NUMBER:
DISTRICT: **LOCATION:** **MUNICIPAL WARD/SUB-LOCATION:**
INTERVIEW NAME: **CODE:**
DATE OF INTERVIEW: DAY/MONTH/YEAR
TIME OF INTERVIEW
VENUE OF INTERVIEW

District departmental heads/parliamentary and civic leaders/ location chiefs/as chiefs/religious leaders/school heads/youth club members/police		
1.	Institutional issues	
	What is the role of your office with regards to the promotion of girls'/women's he this district?	
	When is pregnancy regarded as unwanted in this community? *Probe* How likely is it that such an incident would happen here? Why? *Probe*	
	From your experience in serving in this community, tell me how girls/women wh themselves in this situation cope?	
	What kind of policies does your office have in assisting them?	
	What are the chances that a girl/woman who finds herself in this situation would c you for counsel? *Probe*	
	What other development agencies of community initiatives exist in this district th to promote the health of girls and women.	

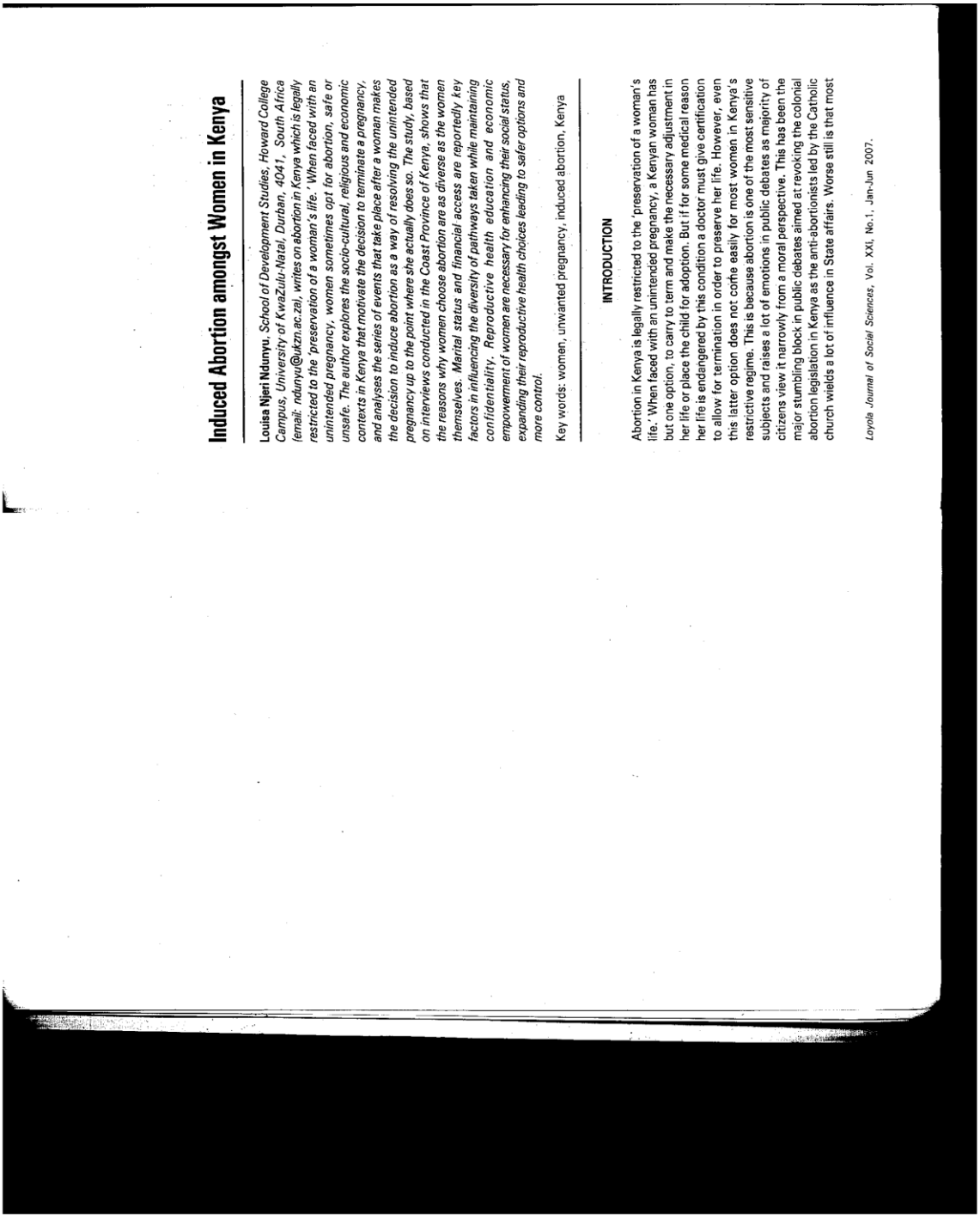
	How do you cooperate with these agencies?	
	Additional questions for service providers	
	Describe to me the kind of methods you use to carry out abortion/post-a procedures? Probe: gestational age	
	How do you ensure safety and sterility during the procedure?	
	What level of training/skills do the personnel have? Probe: PAC skills	
	How would you describe the characteristics of women who seek services i facility?	
	Where do you refer your clients who may require services beyond what you can of	
	How do you cooperate with other agencies to promote the health of women/girls?	
	How would you rate the cost of your services?	
	Additional questions for TBAs/CBDs/ traditional healers/medicine persons	
	For how long have you provided this service in this community?	
	What is your level of training? Probe: PAC skill Where did you receive this training? And by which organization?	
	What organization do you network with?	
	Do you get case of complications from backstreet abortions? What traditional methods of treatment are used?	
	What fees do you charge for services offered?	
	What family planning counseling service do you offer?	
	What are some of the traditional methods of pregnancy prevention used by women community?	
2.	**Social, cultural, religious values and beliefs**	
	Tell me about how the community would react to a situation where a girl/wom terminated a pregnancy? *Probe*	
	What are the cultural beliefs of communities, within the district, with rega premature pregnancy loss?	
	What are the chances that a girl/woman who has had an unwanted pregnancy woul man to marry? *Probe*	
	Describe to me some of the traditional methods used in this community to abortion.	
	Describe to me some of the traditional methods used in this community to p pregnancy. Probe: attitudes towards family planning methods.	
	What are some of your most crucial concerns in relation to girls and women district?	
3.	**Legal issues**	
	Are you aware of abortion legislation in Kenya? -The laws of Kenya permit abortion only if the mother's health is in danger. How perceive this law? *Probe*	
	How in your opinion, does the existing law affect the health of women community? *Probe*	
	If you were to make any suggestions concerning the existing law, what would the *Probe*	
	Additional questions for law enforcers/police	

	How do you enforce the existing abortion law that allows termination of pregnancy only when the mother's health is in danger. How do you identify illegal cases? Explain to me why it appears that offenders are rarely punished until a woman dies from the procedure or some carelessly disposed fetuses are found?	
	Comment on the incidence of willful abortion among girls/women in this commun	

Conclusion:
We are reaching the end of the discussion. Do you have anything to add before I turn off the tape? I think it went well. Do you have any comments on how you feel about the discussion?

Thank you so much for your cooperation

APPENDIX IV: INDUCED ABORTION AMONGST WOMEN IN KENYA



Induced Abortion amongst Women in Kenya

Louisa Njeri Ndunyu, *School of Development Studies, Howard College Campus, University of KwaZulu-Natal, Durban, 4041, South Africa (email: ndunyu@ukzn.ac.za),* *writes on abortion in Kenya which is legally restricted to the 'preservation of a woman's life.' When faced with an unintended pregnancy, women sometimes opt for abortion, safe or unsafe. The author explores the socio-cultural, religious and economic contexts in Kenya that motivate the decision to terminate a pregnancy, and analyses the series of events that take place after a woman makes the decision to induce abortion as a way of resolving the unintended pregnancy up to the point where she actually does so. The study, based on interviews conducted in the Coast Province of Kenya, shows that the reasons why women choose abortion are as diverse as the women themselves. Marital status and financial access are reportedly key factors in influencing the diversity of pathways taken while maintaining confidentiality. Reproductive health education and economic empowerment of women are necessary for enhancing their social status, expanding their reproductive health choices leading to safer options and more control.*

Key words: woman, unwanted pregnancy, induced abortion, Kenya

INTRODUCTION

Abortion in Kenya is legally restricted to the 'preservation of a woman's life.' When faced with an unintended pregnancy, a Kenyan woman has but one option, to carry to term and make the necessary adjustment in her life or place the child for adoption. But if for some medical reason her life is endangered by this condition a doctor must give certification to allow for termination in order to preserve her life. However, even this latter option does not corfie easily for most women in Kenya's restrictive regime. This is because abortion is one of the most sensitive subjects and raises a lot of emotions in public debates as majority of citizens view it narrowly from a moral perspective. This has been the major stumbling block in public debates aimed at revoking the colonial abortion legislation in Kenya as the anti-abortionists led by the Catholic church wields a lot of influence in State affairs. Worse still is that most