SOCIAL AND LEGAL ASPECTS OF ABORTION IN NAIROBI COUNTY

By

Teresa Carlo Omondi

A project paper submitted to the Institute of Anthropology, Gender and African Studies in partial fulfillment of the requirements for the degree of Master of Arts in Gender and Development Studies of the University of Nairobi

November 2011

DECLARATION

This project paper is my original work and has not been presented for a degree in any other university.

.....

Teresa Carlo Omondi

25/11/11

.....

Date

This project paper has been submitted with my approval as the University Supervisor.

.....

Dr. Salome A. Bukachi

25/11/11

.....

Date

DEDICATION

To all the women who are caught between a rock and a hard place, those women who have to choose the "lesser evil", I dedicate this work. It is my belief that someday, someday soon, the society will respond to your voices with viable solutions.

TABLE OF CONTENTS

LIST OF BOXES

LIST OF FIGURES

LIST OF MAP(S)

ACKNOWLEDGEMENT

First and for most I give thanks to God for His abundant grace which has seen me through this work.

Thank you Prof. Simiyu Wandibba and Akademia Nanjala, next to God I owe you my success. Thank you for the push, never ceasing encouragement and holding my hands to this end. Prof. Wandibba receive more gratitude for going out of your way to proof-read the work giving it more meaning; be blessed.

To my cousin Josephat Muyayi, your support and commitment to see me through this work is invaluable. I remain indebted to you. Thank you for walking me through Kibera slums and other parts of Nairobi and introducing to me the first informant, making the snowball sampling a success.

Thank you David Adeshina Adeshina, for solving all my information technology challenges, incredible patience and keeping me company into the wee hours of the night writing up this project paper.

I wish to equally express my gratitude to my supervisor Dr. Salome A. Bukachi for supporting my idea of carrying out this study and the intellectual guidance.

In a special way I wish to thank all the women who bravely took me through their experiences, without whose participation this work would not have materialized. I similarly give thanks to the key informants for enriching the work.

Last, but not least, thank you to my parents, Mr. Michael P. Omondi and Bernadatte A. Omondi who always reminded me that education is power. Dad another *"kofia"* dedicated to you. Thanks to Dr. Charles O. Olungah, Juliet Kassam and Cleophas Wekesa, in your small ways you made a big difference to this work. May God bless you all.

ABSTRACT

This study sought to identify the key social factors that influence women's decisions to procure an induced abortion and the extent to which the legal status of abortion influences the decision to procure or not procure an abortion. The study's overall objective was to explore the social and legal aspects that influence a woman's decision to procure an induced abortion. The study was conducted in Nairobi County, the capital city of Kenya where 30 participants took part in the interviews. The study questions were to find out key social factors that would compel a woman to desire and eventually procure an induced abortion and to what extent the legal status of abortion in Kenya influenced the decision.

Data were collected through in-depth interviews, key informant interviews, case narratives and secondary sources.The study generated qualitative and quantitative data which were organised, tabulated and interpreted in relation to the research objectives and presented as narrative and verbatim quotes according to emerging themes.

The study findings suggest that there are various socio-economic factors that influence women's decision to procure an induced abortion, a major and most common factor being economic instability. Most of the women (67%) stated that they were not economically stable to take care of the unborn. Society perception and stigma was the second most identified factor. These included single mothers' syndrome, rejection by spouse/boyfriend, parental coercion, family rejection, fear of disrupting school or employment. The social perception and stigma were intertwined with economic instability and insecurity.

The study concludes that the legal status of abortion in Kenya is not a crucial factor at the point of women making the decision on whether or not to procure an induced abortion. The distress is usually overwhelming and surpasses thoughts about the law. A key recommendation of the study is that instead of enhancing criminalization of abortion, public resources should increasingly be used in the various, but well known means of prevention of unwanted pregnancies.

ACROYNMS AND ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
CEDAW	-	Convention on the Elimination of All Forms of Discrimination Against Women
CRR	-	Centre for Reproductive Health
CSO	-	Civil Society Organization
FIDA - K	-	Federation of Women Lawyers - Kenya
HIV	-	Human Immunodeficiency Virus
SPSS	-	Statistical Package for the Social Sciences
UN	-	United Nations
WHO	-	World Health Organization

Chapter One

Background to the Study

1.1 Introduction

Whether inflicted upon the mother or upon the child (direct abortion) is against the precept of God and the law of nature: 'Thou shall not kill'. The life of each is equally sacred, and no one has the power, not even the public authority, to destroy it. ...Those who hold the reins of government should not forget that it is the duty of public authority by appropriate laws and sanctions to defend the lives of the innocent, and this all the more so since those whose lives are endangered and assailed cannot defend themselves. Among whom we must mention in the first place infants hidden in the mother's womb (Pope Pius XI, 1960: 35).

If we were all to take up responsibility for our actions, the abortion debate as a matter of law would be much watered down to individual morals and responsibility. Our reckless actions cannot be protected under law, only under the extreme circumstances of rape and incest; the rest is a matter of personal responsibility. The sole responsibility of a government is to protect life, liberty, and the pursuit of happiness. All other laws are debatable from the perspective of their applicability to human rights and liberty. Abortion is wrong because it is a poor precedence for any legislature to follow. Our duty is to protect life not to compromise it (Nyoike, 2007: 1).

The above statements are just a sample of comments made on the debate about legalizing or not legalizing abortion. The first statement represents the religious perspective which is known to greatly influence the social lives of people and second statement represents the legal approach that provides for laws that govern the people.

In medicine, according to Webster's New World Medical Dictionary (MedicineNet.com, 2008: 33), abortion is defined as premature exit of the products of conception (the foetus, fetal membranes and placenta) from the uterus. It is loss of a pregnancy and does not refer to why the pregnancy was lost. The dictionary also defines the various types of abortion. The first is therapeutic abortion which is defined as abortion brought about intentionally. It is also referred to as induced or artificial abortion. The second is miscarriage of three or more consecutive

pregnancies, and is termed habitual abortion or spontaneous abortion (The MedicineNet.com Doctors, 2008:33).

Spontaneous abortion is not viewed as illegal nor immoral since it is believed that the woman had no control over the circumstances. Induced abortion, on the other hand, is the commonly detested for it has ethical and legal ramifications, whether done to save the mother's life or simply because it is an unwanted pregnancy. This is the subject of heated debates and the basis of this study. Women's ability to obtain abortion services is said to be largely affected by the prevailing law and social norms in a particular country. A majority of countries that criminalize the procedure do have exceptions only in certain circumstances, for example, in cases of sexual violence or when medically stated to be a risk to the mother's life (CRR & FIDA Kenya, 2007).

Unfortunately, the said exceptions are frequently unwritten or ambiguously worded and not easily understood by healthcare providers and women seeking the services. The laws on abortion are also often addressed in multiple statutes, codes and regulations making health workers reluctant to provide the service even where women are legally entitled to the facilities (IPAS, 2003). In addition to legislation and policies, religion, customary laws and social judgment, level of education, economic status and gender, play a role in determining whether or not women can fully and freely access their reproductive health rights. Cultural values, such as children being seen as a symbol of the wealth one has, are reinforced by religious norms which emphasize the aspect of giving birth and filling the world, "Be fruitful and increase in number; fill the earth and subdue it..." (Genesis 1:28).

The great stigma against abortion and its criminalized status, imperils women's health and harms medical practitioners who provide abortion-related care. According to an in-depth analysis of WHO's national mortality figures by the National Right to Life Committee (Terrence, 2010), evidence from various reports show that a country's maternal mortality rate is determined to a greater extent by the quality of medical care and by the legal status of abortion. Abortion complications are not only shaped by the legality of the procedure, but also by the overall medical circumstances in which it is performed and a large section of the society that promotes its interest in protecting the life of the unborn human being.

Human rights treaty bodies are increasingly concerned with the high rates of preventable maternal death and are characterizing governmental failures to address pregnancy-related deaths as violation of women's right to life (CEDAW, 1997). These bodies are increasingly advocating for legal reforms on abortion to make the process medically safe for women and girls.

World statistics show that every year over half a million women worldwide die from the complications of pregnancy and childbirth (IPAS, 2003). The vast majority of these maternal deaths occur among the world's poorest women. In statistical terms, a woman's life-time risk of dying from pregnancy in Africa is 1 in 16 (WHO *et al.,* 2000). Of course, issues of access, quality of care and costs are contributing factors.

Abortion remains illegal in Kenya, but for a wide variety of reasons women often undergo unsafe procedures which result in the death of many; the deterrent laws have not stopped these women. Article 26 subsection 2 of the Constitution of Kenya (GOK, 2010) provides that life of a person begins at conception; subsection 3 states that 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. This constitutional provision still upholds that abortion is illegal but the inclusion of the exception was met with a lot of criticism by various sections of religious leaders and a section of Kenyans in general who felt the supreme law was permitting abortion in Kenya through the exception.

As earlier described, the exceptions are subject to various scrutiny and processes that in themselves are deterrent. Provision of exceptions has always been the position of the Kenyan Penal Code (GOK, 1960), in instances of rape and danger to the mother's health. The exceptions, however, do not in any way approve induced abortion but only give room for services in case of miscarriages and where medically determined. Currently there is no legislation to provide guidelines as to how the opinion of the trained health professional will be implemented or any other written law as stated by the Constitution, hence maintaining the situation prior to the promulgation of the new Constitution in 2010.

Socially, Kenya continues to nurture an enormous problem of maternal mortality attributed to unsafe abortion. A recent study by CRR (2010: 25-26, 107) shows that:

- 35% of maternal deaths are due to unsafe abortion.
- Kenya's fatality rate associated with abortion-related complications is higher than the rate for Africa by about 30%, more than two fold higher than in less developed regions and the global rate, and more than nine fold higher than the rate for more developed regions.
- 2,600 women die annually in Kenya from complications of unsafe abortion.
- 21,000 women are hospitalized annually in Kenyan public hospitals for treatment of abortion related complications, incomplete and unsafe, spontaneous or induced.
- Only 6% of hospitals, maternities and health centres in Kenya offer comprehensive emergency obstetric service.
- Only 11% of all government managed facilities have the basic components to support 24-hour emergency services.

A national assessment of the magnitude and consequences of unsafe abortion in Kenya (IPAS, 2003:42) revealed the following:

- 300,000 abortions are performed in Kenya each year.
- 20,000 women and girls are hospitalized with abortion-related complications.
- 48% of abortions occur in women 14 to 24 years.
- 57% of the women who procure abortion come from urban areas.

Women leave behind millions of motherless children whose survival is precarious due to lack of maternal support and care. According to the Kenya national post-abortion care curriculum (GOK, 2003) children who are left motherless due to maternal mortality are up to 10 times more likely to die within two years than children with two living parents. A majority of unmarried women fear the stigma that comes with getting a child out of wedlock and the assumption that single women are either socially or financially incapable of supporting a child. Other reasons include unemployment, economic dependence on parents or relatives, infidelity where the woman is unable to tell who the father of the child is in cases of multiple partners or in some cases pregnancy as a result of adultery (Baker and Khasiani, 1991).

Ignorance about contraceptive methods is also one of the prevailing causes of high abortion in Kenya. Around 85% of the girls aged 15 – 19 years and 72% of those aged 20 - 24 years

reportedly do not use contraceptives (Guttmacher Institute, 2008). In Kenya, 70% of adolescents reportedly engage in unprotected sex, 40% of births are unplanned and one in four married women have unmet need for contraceptives (Guttmacher Institute, 2008).

1.2 Statement of the Problem

Notwithstanding the high restrictions surrounding induced abortion, many women are still undergoing the procedure. National estimates of abortion in Kenya are based on studies on women with abortion-related complications who report to public health facilities especially public hospitals. Thus, little or nothing at all is said about women who experience abortion complications but seek treatment from private facilities and/or those who do not require hospitalization in the public facilities (Guttmacher Institute, 2008). The recorded death of over 2,600 women per year in Kenya (CRR, 2010) caused by unsafe abortion is a substantial economic and social cost, not only for the woman in question but also for her loved ones and the Kenyan society at large.

Abortion is a reality in Kenya and continues to have implications for those who procure and those who help to procure induced abortion. Abortion is not only a moral issue but also a legal issue with several socio-economic repercussions.

Further, there are various concerted efforts by women human rights organizations, non-governmental health organizations, feminists and women groups calling for legal reforms as the sole panacea to unsafe abortion. However, very little is being done to address the underlying causes of abortion and/or the major factors that inform women's decisions to abort. What is wrong with our society that we are experiencing an increase in maternal mortality caused by induced abortion? It would be motivating to find out why women procure induced abortion and why some professionals help these women to procure induced abortion

This research endeavoured to answer the following questions:

a) What are the key social factors that would compel a woman to desire and eventually procure an induced abortion?
b) To what extent does the legal status of abortion in Kenya influence the decision of a woman to or not to procure induced abortion?

1.3 Objectives of the study

1.3.1 General objective

To explore the social and legal aspects that influence on a woman's decision to procure an induced abortion.

1.3.2 Specific objectives

- To establish the key social factors that would compel a woman to procure an induced abortion.
- To examine the extent to which the legal status of abortion in Kenya influences a woman to procure or not procure an induced abortion.

1.4 Justification of the study

Addressing the real issues that inform women's decisions to abort is likely to create success in reducing the number of deaths currently experienced as a result of botched abortions. A key method to arrive at a sustainable solution would be a critical analysis of women's fears and concerns in decision-making.

The findings of this study add to other academic studies that have investigated the underlying causes of abortion in Kenya. The study should also be useful to women/human rights organisations championing women reproductive rights to develop effective advocacy strategies.

1.5 Scope of the study

Whereas the study appreciated that there are various underlying factors that lead to the decision to procure an induced abortion, including religious, social and cultural factors, it specifically targeted legal (policy and legislation) and socio-economic factors as those that influence women's decisions.

The study was conducted in Nairobi and was largely based on the experiences and opinions of participants to deduce the societal perception on induced abortion and explore the existing Kenyan laws on abortion.

1.6 Limitations of the study

Due to societal stigma it was quite challenging to get women who have procured an induced abortion to share their story. Abortion remains a sensitive topic, the women are only free to share with their close friends who have similar experience, they are afraid of being judged or questioned about their actions.

A majority of the key informants, especially those working in the health sector, would only provide information at a very general level to some extent affecting the quality of information. The informants did not wish to disclose their clients' story, as this would be professionally unethical. Some of the professionals also depicted reluctance in freely expressing their views, cautious that they do not seem to take sides especially with the controversial debates surrounding legality of abortion in Kenya. However, the legal professionals were more open to discuss cases within their dockets, giving specific examples.

1.7 Definition of key terms

Abortion – the premature exit of the products of conception (the foetus, fetal membranes and placenta) from the uterus. It is loss of a pregnancy but does not refer to why the pregnancy was lost.

Induced abortion – abortion brought about intentionally. It is also referred to as artificial or therapeutic abortion.

Legal aspects – the implications of the Kenyan laws, policies or regulatory frameworks on abortion.

Social aspects – factors that affect or direct an individual's life with specific reference to socio-economic status, including education background.

Unsafe Abortion – procedure of terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.

Women – in this study, women referred to females aged 18 years and above. They comprised the population of females in the child-bearing age who had procured an induced abortion.

Chapter Two

Literature Review

2.1 Introduction

The literature review provides the context of abortion in Kenya as compared to other African countries and the world. This chapter discusses the problem of abortion in Kenya and efforts that have been made by various stakeholders to rectify the situation. The chapter further analyses the problem from a general legal and social perspective globally and thereafter focuses on the situation in Kenya, reviewing various motivations that expose women to unsafe abortion. Finally, the chapter presents the theoretical framework and assumptions that will guide the study.

2.2 Legal Aspects of Abortion

2.2.1 General legal view on abortion

Abortion laws in Africa are the most restrictive in the world. Correspondingly, Africa has the highest mortality due to abortion in the world, an estimated 680 deaths per 100,000 procedures (Gutt, 1999). South Africa remains the only African country in the Commonwealth which has legislation allowing abortion without restriction. This freedom is enshrined in the South African Choice of Terminations of Pregnancy Act (RSA, 1996), which was amended in 2008 to expand this freedom. The expanded freedom exempts a facility offering a 24-hour maternity service from having to obtain approval for termination of pregnancy services under certain circumstances, provides for the recording of information and the submission of statistics, and enables a member of the executive council to make favourable regulations (RSA, 2008).

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (AUC, 2003) is the 1st international human rights instrument which explicitly obligates state parties to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. Twenty-eight countries out

of the fifty-four have ratified the protocol and made their abortion laws less stringent (AUC, 2003).

Apart from civil rights issues, the Convention on Elimination of all forms of Discrimination Against Women (CEDAW, 1979) also devotes major attention to women's reproductive rights. The convention does not have a specific clause on abortion but its provisions speak to aspects of the problem. The preamble to the convention sets the tone by stating that "the role of women in procreation should not be a basis for discrimination". The link between discrimination and women's reproductive role is a matter of recurrent concern in the Convention. For example, it advocates, in article 5, "a proper understanding of maternity as a social function", demanding fully shared responsibility for child-rearing by both sexes. Accordingly, provisions for maternity protection and child-care are proclaimed as essential rights and are incorporated into all areas of the Convention, whether dealing with employment, family law, health-care or education (CEDAW, 1979).

Society's obligation extends to offering social services, especially child-care facilities that allow individuals to combine family responsibilities with work and participation in public life. Article 4 (CEDAW, 1979) provides that special measures for maternity protection should be recommended and "shall not be considered discriminatory". The Convention under Article 16.e (CEDAW, 1979) also affirms women's right to reproductive choices. State parties are obliged to include advice on family planning in the education process and to develop family codes that guarantee women's rights "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".

2.2.2 The Kenyan situation

For over half a century, as provided by the Kenyan penal code (GOK, 1960), abortion has remained illegal and only permitted in exceptional cases where the life of the mother is in danger. This position was retained on promulgation of the new Constitution of Kenya (GOK, 2010) where Article 26 provides that abortion is not permitted unless, in the opinion of a trained

health professional, there is need for emergency treatment, or life or health of the mother is in danger or if permitted by any other written law.

It is, however, important to note that the new Constitution (GOK, 2010) came with some relief. Several provisions in Kenyan laws, that in one way or another influenced the decision of women to procure an induced abortion, are now subjects of repeal and/or automatically fell unconstitutional on the date the Constitution was promulgated. An example of legal provision that automatically fell unconstitutional is the Children's Act (GOK, 2001) section 24 (3). The section provided that where a child's father and mother were not married at the time of the child's birth, and have not subsequently married each other, the mother shall have parental responsibility at the first instance and the father shall subsequently acquire parental responsibility for the child. This provision locked out children born out-of-wedlock from being automatically supported by their fathers. Fathers had an option to, or not to, own up and apply for the parental responsibility; a comfort zone for men who deliberately neglected women they had impregnated or are just were not willing to take up any responsibility of raising children they had fathered. A study by Baker and Khasiani (1992) showed that the most common reason why single women decide to procure an abortion, is the fear of being stigmatized for getting pregnant out of wedlock and raising the child as a single parent.

Kenya's Penal code (GOK, 1960) declares that it is an offence for 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 14 years. It is also an offence for a woman to attempt to procure the abortion herself. The code, however, provides a distinction between killing a foetus and murder of a newly born child; a child becomes a person capable of being killed when it has completely proceeded in a living state from the mother's body whether it has breathed or not, whether it has independent circulation or not or whether the navel string is severed or not. Other offences include illegal provision of a device that could be used to procure an abortion or person involved in the publication of advertisement referring to any drug or appliance that may lead to the securing of an abortion for a woman under the Pharmacy and Poisons Act (GOK, 1957). The Medical Practitioners and Dentists Act (GOK, 1978) renders it criminal for any person other than a registered, licensed medical practitioner to

practise medicine or perform surgery in Kenya; only a doctor registered under the Act can perform a lawful abortion procedure.

In light of the stringent laws, it is, however, interesting to note that the Kenya Government, through the Ministry of Health, has clear policy on emergency care for complications of abortion, both spontaneous and induced; the service is legal and not punished by any law in Kenya (Division of Reproductive Health, 2005). This can be assumed that the Government is aware that abortions take place and that restrictive laws seriously violate and undermine women's' human rights. The Government in this situation is similarly reactive and not proactive in addressing the abortion problem. The post-abortion care is also only restricted to reproductive health as a population issue limited to family planning rather than a holistic perspective of reproductive health.

2.3 Social Aspects of Abortion

2.3.1 General view on social aspects of abortion

An obvious ethical issue in abortion concerns the moral status of the embryo/foetus. Some think that the ethical principle to do no harm, requires that the interest of the embryo should prevail over the interest of the woman. Others think that the ethical principle of respect for persons, requires that there is consideration and regard for women's autonomous choices, that is, respect for persons, requires that we treat women not as instruments of governmental birth control policies (South Africa High Court, 1998). Moreover the ethical principle of beneficiaries might well favour the women taking critical decisions on behalf of the family and dependent children.

Cook et al.(2003) state that justice might require accommodating the plurality of views on this issue by ensuring that the laws respect those who conscientiously object to the procedure but also allows for the provision of service for those who have conscientiously decided that they need such services.

African women remain the most affected by abortion; globally 70,000 women die annually from abortion and over half are from Africa (IPAS, 2003). The World Health Organization estimates that 38,000 women are dying annually in Africa which translates to 100 women per day. In

Kenya 2, 600 out of 300,000 women who procure abortion die per year (CBS et al., 2004). Cook et al. (2003) state that it is widely accepted by laws in different countries that abortion is lawful when undertaken to save a pregnant woman's life; 61% of the world's people live in countries where induced abortion is permitted either for a wide range of reasons or without restriction as to reason. However Cook et al. (2003) argue that ethical challenge is aggravated by uncertainty in the meaning of law which is expressed in ambiguous yet commonly used language. If society appreciates abortion, it will really not matter how the law is framed provided it gives the same meaning as to the societal expectation.

2.3.2 Kenyan situation on social aspects of abortion

A shadow report by the Centre for Reproductive Rights (2010: 57) summarizes some of the barriers of safe abortion as:

1. Legislations of a country (criminalization of abortion)
2. Lack of awareness, knowledge and information by women on safe services if at all.
3. Economic barriers, a majority of the world's poor are women and the longer it takes raising funds for the service the more costly is the service.
4. Difficulty in finding the service provider who will accept to carry out the service.
5. Distance to the nearest service provider.
6. Third-party involvement, for example, young girls would need parental consent whose decision might not always be favourable to the girl or spousal approval for the older women. In some cases it involves use of family resources to finance medical services.
7. Biased pre- and post-counselling – some providers would like to instill their religious convictions on the women seeking abortion services.
8. Gender stereotypes:

    - Girls are married for emotional closeness and motherhood while men marry for sex and domestic support.
    - Girls do not have a natural sex drive, any interest girls may have in sex results from unfortunate social conditioning, that is, the girls' primary responsibility is to be modest and to ensure that boys do not get to have premarital sex with them.

- Girls who surrender to sex lack self-respect and are undeserving of the love and respect supposedly afforded to be virgins.

From the arguments above, it is apparent that the abortion debate has historically been expressed only in prohibitive terms, judged from a background of unskilled and harmful practices and often reinforced by religiously inspired moral agenda. During debates prior to the referendum for Kenya's new Constitution, the church managed to take control of the abortion debate giving it a moral dimension that even superseded the faith teachings. The church argued that abortion was the same as murder because life begins at conception. The Cannon Law of the Catholic Church, Cannon 1398, prescribes expulsion from the church of any Catholic who procures an abortion (Catholic Christian Article, 2004).

The sanity of the pragmatic voice lies in its reasoning that abortion is in most cases the last resort, a decision taken after all options are found to have failed or likely to harm the mother. The benefits of pragmatic thinking lie in its meeting day to day realities of women and that abortion is a practised reality in Kenya. If life is scared and the sanctity is applied with equal measure to all, there should be a better balance to also save the life of the 2,600 women and girls who die annually in Kenya (CBS et al., 2004).

One of the key bits of information collected for the Kenya Demographic Health Survey (2008 – 2009) was use of family planning methods or contraceptives. The results showed that currently married women record contraceptive usage at 46% up from the 39% reported in the Kenya Demographic Health Survey of 2003 and other studies. Young people aged 15-19 recorded the lowest contraceptive prevalence while 53% of urban and 43.1% of rural women use contraception. Regions with highest consumption of contraceptives are: Central (67%), Nairobi (55%) and Eastern (52%) whilst the poorest consumer region is North Eastern with 3.5% (KNBS and ICF Macro, 2010). The statistics confirm fears that most women still do not know or use contraceptives that would prevent unwanted pregnancy. The harmful causes of unwanted pregnancy are a myriad. When a woman decides to end an unwanted pregnancy she is exposed to the risks of unsafe and illegal abortion. In the alternative, when a woman carries an unwanted pregnancy to term there can be physical and mental health consequences as well as potential economic and social ramifications (WHO, 1997).

Women may appear silent in the whole abortion debate in Kenya but the statistics speak loud on what their experience is. Influenced by various factors, over 300,000 abortions take place per year (IPAS, 2003), a possible conclusion that women's voices were loud through silent votes during the referendum for a new Constitution amidst great NO vote campaigns against the exceptions for permitted abortion. According to the Kenya Demographic and Health Survey for 2003 (CBS et al., 2004), 20% of births in Kenya are unwanted and an additional 25% are mistimed, making it a total 45% of pregnancies unplanned for. Abortion is a deep moral issue with profound psychological and physiological consequences which can only be appreciated by the person concerned, whether it was procured legally or illegally.

2.4 Theoretical Framework

The study was guided by the theoretical thinking based on the natural law theory with specific reference to the principle of double effect.

2.4. 1 Natural law theory

Natural law or the law of nature (Latin: *lex naturalis*) is a theory that posits the existence of a law whose content is set by nature and has validity everywhere. It has been studied and refined over the centuries as a means of addressing what is the morally right thing for us to do when faced with genuine moral dilemmas (McIntyre, 2004). The theory of natural law was put forward by Aristotle, a Greek philosopher, but championed by Saint Thomas Aquinas (1225 – 1274) who was the foremost classical proponent of natural theology, an immensely influential philosopher and theologian in the tradition of scholasticism known as *doctor angelicus* (the angelic doctor) and *doctor communes* or *doctor universalis* (the common or universal doctor) (Jacobs, 2010).

Natural law theory posits that all humans can discover what is right since it is written in their nature, in some way. Thus, the theory has had many proponents across the world dating back to Aristotle (Vardy, 1999). The basic precepts of natural law theory are proximately grounded in an objectively knowable human nature; they are applicable to all human beings, precisely because we all possess such human natures (McIntyre, 2004). The possession of natures which are specifically human is precisely what we all have in common. This is true regardless of time, culture, background, race, sex, religion or political affiliation.

2.4.2 Principle of double effect

Double effect is a part of natural law ethical theory and was gradually refined over the centuries in order to meet the unfortunate but very real moral dilemmas in which, no matter what is reasonably done, one or more innocent human beings may be harmed or even die in the process of resolving the dilemma. Thomas Aquinas is credited with introducing the principle of double effect in his discussion of the permissibility of self-defense in the *Summa Theologica* (II-II, Qu. 64, Art.7) (Jacobs, 2010). Killing one's assailant is justified, St. Thomas argues, provided one does not intend to kill him.

Aquinas observes that "Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention. ... Accordingly, the act of self-defense may have two effects: one, the saving of one's life; the other, the slaying of the aggressor" (Jacobs, 2010: 52). As Aquinas's discussion continues, a justification is provided that rests on characterizing the defensive action as a means to a goal that is justified: "Therefore, this act, since one's intention is to save one's own life, is not unlawful, seeing that it is natural to everything to keep itself in being as far as possible" (Jacobs, 2010: 52). However, Aquinas observes that the permissibility of self-defense is not unconditional: "And yet, though proceeding from a good intention, an act may be rendered unlawful if it be out of proportion to the end. Wherefore, if a man in self-defense uses more than necessary violence, it will be unlawful, whereas, if he repel force with moderation, his defense will be lawful" (McIntyre, 2004: 165).

2.4.3 Relevance of the theory to the study

Although abortion is illegal and viewed by a majority to be morally wrong, those who procure induced abortion feel justified for various reasons. Baker and Khasiani (1992) provide some of the reasons including fear of stigma of raising children as single mothers, career protection and lack of financial resources.

The principle of double effect holds that it is morally allowable to perform an action that has a bad effect under four conditions (McIntyre, 2004:166) mentioned below:

First, **the action to be performed must be good in itself, or at least indifferent.** The principle of double effect as applied to the case of abortion renders abortion procedures morally illicit, since the action by its very nature is evil. However, possible medical actions, for example, the removal of a cancerous uterus is morally good or at least a neutral act that could be permitted in order to save the life of the mother, even if it could possibly result in the unintended death of the unborn child, as long as all of the other three following conditions are also met.

Second, **the evil effect must not be directly intended for itself but only permitted to happen as an accidental by-product of the act performed.** In application, this implies that abortion is accepted only as a by-product of saving the mother's life. The death of the unborn child was not directly intended.

Third, **the good intended must not be obtained by means of the evil effects. In application, this means that** during the abortion procedures, the death of the unborn child must not be used as a means of limiting family size, preventing birth defects or enhancing a career.

Finally, **there must be a reasonably grave reason for permitting the evil effect.** If the good is slight and the evil great, the evil can hardly be called incidental. If there is any other way of getting the good effect without the bad effect, this other way must be taken.

The study relied on the fourth condition of the double effect theory to analyse the reasons given in making the decision to procure an induced abortion; could it be a choice of lesser evil? Is there any other way of getting the good effect without the bad effect? Natural law precepts guided the understanding of the informants' views on social factors and legal reasoning for or against abortion.

2.5 Assumptions

The following assumptions were formulated to guide this study:

i. Socio-economic factors compel women to procure an induced abortion.
ii. The legal status of abortion plays a key role in women's decision to procure an induced abortion.

Chapter Three

Research Methodology

3.1 Introduction

This chapter describes the research methodology. It provides information on the research site, research design, study and sample populations, and methods of data collection and data analysis. Finally, the chapter discusses the ethical considerations observed before, during and after the study.

3.2 Research site

3.2.1 Location

The research was carried out in Nairobi, the capital city of Kenya which has a population of 3,138,369 of whom 1,533,139 are females and 1,605,230 are males. Nairobi is located on the Nairobi River in the central highlands, in the south-central part of the country. The city lies on the central Kenyan plateau at an altitude of about 1,680m (Google, 2011).

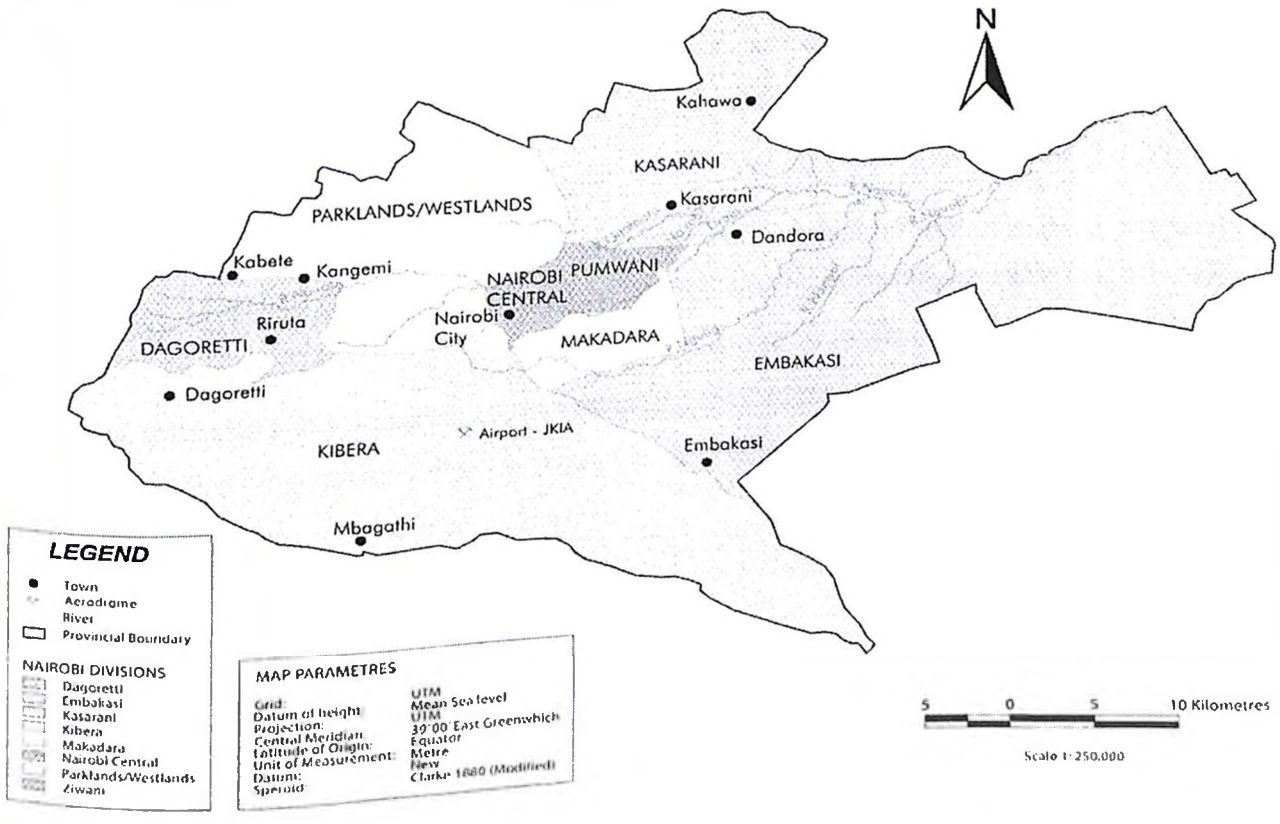

Figure 3.1: Map of Nairobi

3.2.2 Economic activities

Nairobi is now one of the most prominent cities in Africa, politically and financially, and has people from all aspects of life. The city commands the largest share of modern sector wage employment in Kenya and with basic minimum wage of Kshs. 9,461 in 2009 (KNBS, 2010:71, 80). A majority of the city dwellers earn their living from various informal employment including casual labour in factories and construction sites, small businesses, entertainment sites, and carrier of goods (KNBS, 2010:81). Nairobi also hosts the largest informal settlement in Kenya (Kibera) with a population of 355, 188 of whom 169, 252 are females and 185, 836 are males (KNBS and ICF Macro, 2010). This informal settlement hosts women who have moved through various income brackets during their lives, and have most likely been faced with the dilemma of induced abortion.

3.2.3 Reproductive Health

The family planning needs of Kenyan women are still not being met. Nairobi has 45% of women in their reproductive health age who are either not aware of contraceptives or do not use contraceptives (KNBS, 2010).

3.2.4 Education

Levels of education are higher in Nairobi city than in other parts of the country. For example, Nairobi has 15.4% attainment of secondary school education followed by Central Province which is at 5% (CBS et al.,2004). Academic level is useful in terms of rating the perceptions of the informants especially in terms of understanding procedures and general effects of abortion. The literacy level impacts on ability to engage in discussions around existing laws and access to information that impacts on women's' lives.

3.3 Research design

This was a cross-sectional exploratory study. The research was carried out in Nairobi and targeted both the slum and formal settlements. Data were collected through in-depth interviews, key informant interviews, case narratives and secondary sources. Findings of the study have been presented as narratives and verbatim quotes according to emerging themes.

3.4 Study population

The study population consisted of women aged 18 – 40 years in Nairobi who have procured an induced abortion. The individual woman who had procured an induced abortion was the unit of analysis.

3.5 Sample population

The study targeted 30 individuals all based in Nairobi: 15 women who had procured induced abortion and 15 male and female professionals.

3.6 Sampling procedure

The study employed snowball sampling. The first informant was a lady known to the researcher who had procured an abortion and who thereafter made referrals to other informant. Purposive sampling was used for the selection of the key informants.

3.7 Methods of data collection

3.7.1 Secondary sources

In addition to documents utilised for the literature review, further reading was done to give more insight into the research and allow comparison to other jurisdictions specifically the factors that inform decisions surrounding abortion. Journals, theses, government publications and books were used to gather background information to the study. These sources were continuously used throughout the entire period of the study.

3.7.2 In-depth interviews

A semi-structured interview schedule (Appendix 1) was used to get detailed information from the women who have procured an induced abortion. The method was used to get the women's thoughts and behaviour and explored the underlying issues in depth. The method was also used to seek individual interpretations of informants on the issue of abortion. Twelve women who have procured an induced abortion were interviewed.

3.7.3 Key informant interviews

Key informant interviews were used to collect information from professionals who have had direct or indirect engagement with women who have procured an induced abortion. The key informants included 2 advocates, 1 magistrate, 2 prosecutors, 3 counsellors, 1 representative of non-governmental organisations addressing women's reproductive rights, 2 religious leaders, 2 gynaecologists, 1 senior official from Ministry of public health and sanitation and 1 from Ministry of gender, social services and children affairs. The study sought professional views on the social and legal aspects of abortion. A key informant interview guide (Appendix 2) was used to gather the information.

3.7.4 Case narratives

Case narratives took the shape of relaxed conversations where the women would take a tour of their experiences. There were some questions about their social and legal views on abortion (Appendix 3). Three women who had procured an induced abortion were interviewed.

3.8 Data processing and analysis

Once the information was obtained, a data entry matrix reflecting different categories was developed and the data entered into the matrix. The information was thereafter tabulated according to frequency of events. The study generated both quantitative and qualitative data which was organised, tabulated and interpreted in relation to the research objectives. The qualitative data was presented as narrative and verbatim quotes according to emerging themes. Due to the small number of informants, quantitative data was manually calculated to achieve the recorded percentages.

3.9 Ethical considerations

A clear explanation of the purpose of the research was given to all informants. A written and informed consent was obtained from each informant before, during and after data collection. Strict confidentiality and anonymity was continuously promised and ensured. All referrals to persons in the report is anonymous, pseudonyms have been used. The study adhered to the principle of ensuring no harm to the informants. Clearance by the Ministry of Higher Education, Science and Technology was sought and every informant informed of their right to withdraw from the study, if they so wished.

Chapter Four

Study Findings - Social & Legal Aspects of Abortion

4.1 Introduction

This chapter presents the statistical characteristics of the study population, providing information on the informants' social status and interaction with the law. The chapter also narrates the experiences of the women who have procured an induced abortion and analyses their general life style. The information was gathered using in-depth interviews, case narratives and key informants interviews.

4.2 Demographic characteristics of the informants

4.2.1 Age

A total of 15 women who had procured an induced abortion were interviewed. The youngest informant was aged 18 years and the oldest 42 years. Forty per cent of the women were aged 18-24 years, 33% were aged 25 – 29 years, 13% were aged 35 – 39 years and 7% each for ages 30-34 years and 40 - 44 years. The mean was 26.6 years. These findings are summarized in Figure 4.1 below.

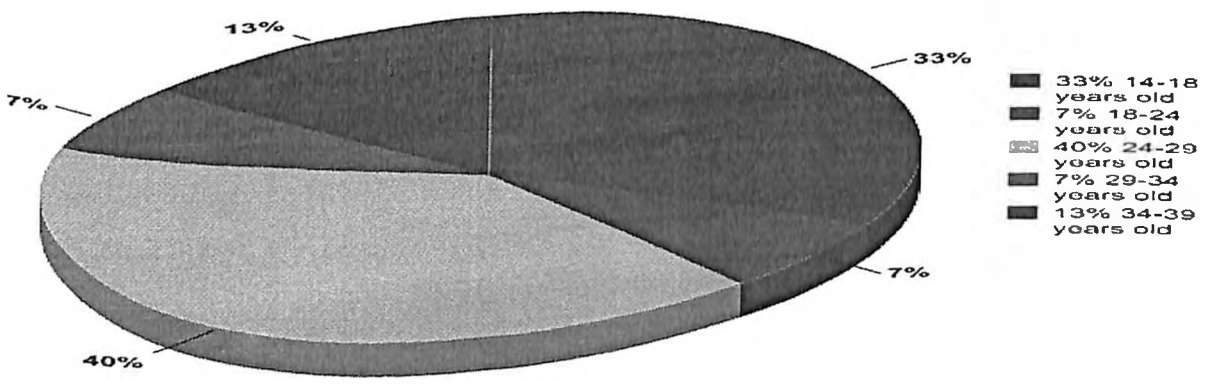

Figure 4.1: Age of informants

4.2.2 Marital Status

Over half (53%) of the informants were single, 40% were married and 7% were separated (Figure 4.2). This finding supports that by Baker and Khasiani (1992) who identified single women as being most prone to procuring an induced abortion. One reason for this is the fear of being stigmatized for getting pregnant out of wedlock and raising a child as a single parent.

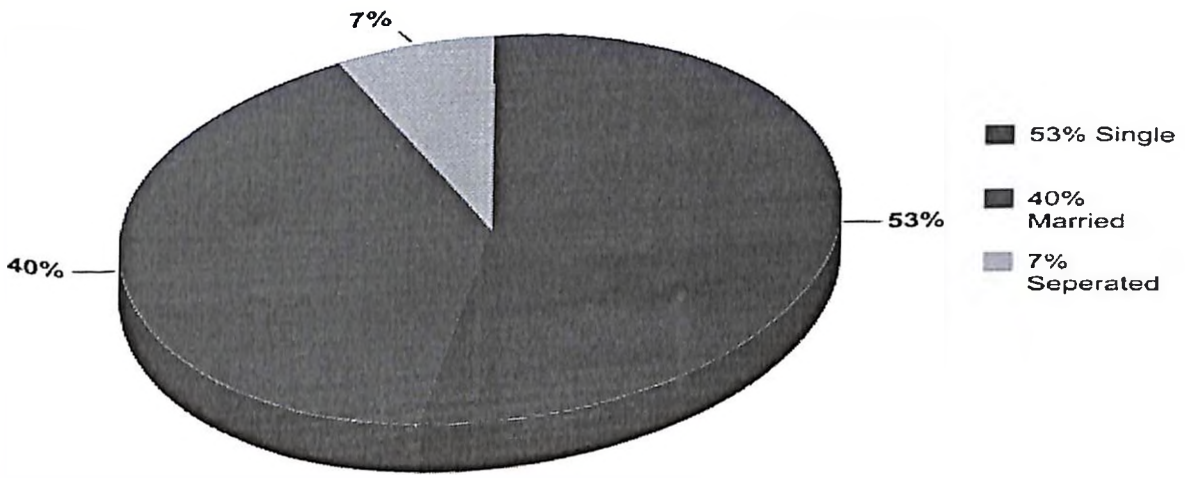

Figure 4.2: Marital Status

4.2.3 Level of education

Eleven per cent of the informants had not been to school at all. This was attributed to past gender discrimination where only boys would be taken to school. The informants however expressed interest in joining adult education at least to learn how to read and write. The remaining 89% of the women had been to school, with the highest level being form 4 and the lowest being standard 6. Twenty-nine per cent completed primary school standard 8. Another 29% attained primary level standard 6, 21% attained primary level standard 7, 14 % completed secondary school form 4 and 7% reached secondary level form 2.

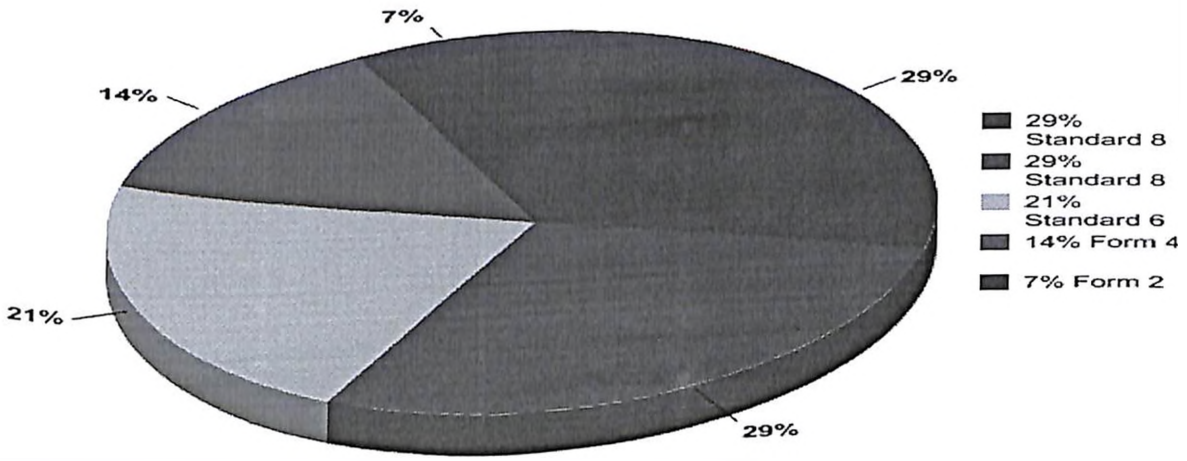

Figure 4.3: Education levels of the informants

4.2.4 Occupation

Sixty-seven per cent of the informants were employed, both formally and informally, earning an average of five thousand shillings (KES. 5,000) per month. The remaining 33% were unemployed and had no source of income. The unemployed women relied on irregular casual jobs or on their male partners (spouses or intimate friends).

Those in formal employment worked as office assistants (cleaners), secretaries and cooks in city restaurants. On the other hand, those in informal employment included small-scale traders such as fish mongers, house maids, shopkeepers (kiosk operators), second hand clothes vendor and salonists. The highest wage was ten thousand shillings (KES. 10,000) and the lowest three thousand shillings (KES. 3,000).

4.2.5 Religious affiliation

The study considered religion to explore its significance in the decision-making process and general way of life of the informants. A majority of the informants were Christians; 46.7% being Protestants and 33.3% being Catholics. Twenty per cent were Muslims (Figure 4.4). All the informants acknowledged that religion was one of the things they thought of when making the

decision to procure an induced abortion. They stated that they had a relationship with God and felt their decision would go against His commandment, "do not kill". However, at the same time, the informants believed that God would forgive them considering the prevailing circumstances of their decision. Most (95%) of the informants remain actively committed to their faith while 5% shy off from active participation as they still feel guilty to have offended God.

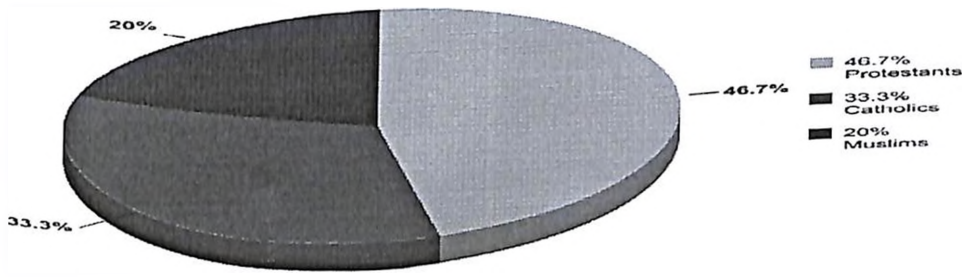

Figure 4.4: Religious affiliation of the informants

4.2.6 Number of children per informant

Sixty per cent of the informants had an average of 2 children per woman while 40% had no children. For those who had children, 44% had one child, 34% two children and 22% five – six children. The lowest number of children was 1 and the highest 6.

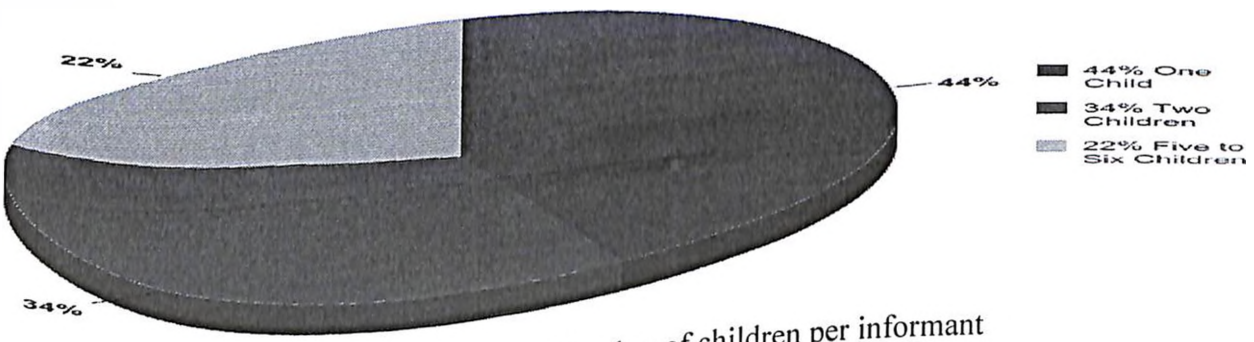

Figure 4.5: Number of children per informant

4.2.7 Other dependants per informant

Sixty per cent of the informants stated that they had other dependants apart from their nuclear family. The dependants were of variant types within the extended family, including parents, younger siblings, children of deceased siblings (nephews and nieces) and children of house maids working for them. The remaining 40% stated that they do not have dependants. Forty-four per cent of the informants with dependants had more than one category of dependants (Figure 4.6). For example a informant would have her mother, sibling and niece as dependants.

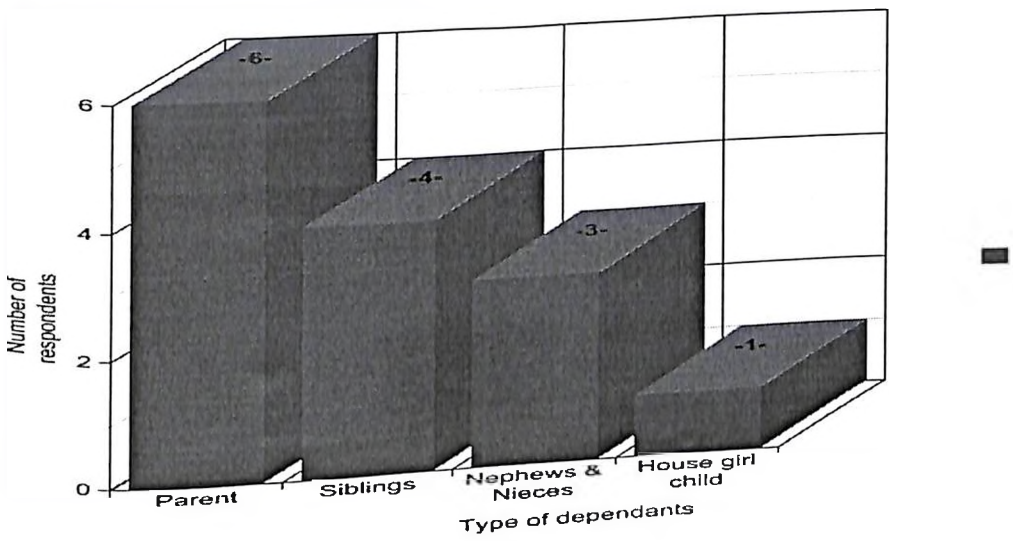

Figure 4.6 Category of dependants per informant

4.3 Additional characteristics of the informants

4.3.1 Age of the informants at time of procuring first abortion

The study findings indicate that 40% of the informants procured their first abortion at the age of 25 – 29 years, 33% were 14 – 18 years, 13% were 35 – 39 years and 7% each were aged 18 – 24 years and 30 – 34 years respectively (Figure 4.7). The mean age was 25 years, meaning that a majority of women who procure an induced abortion are above the age of 25 years. This compares well with results from a national study (Guttmacher Institute, 2009) of women admitted to public health facilities for abortion-related complications. The Institute's study showed that 40% of the women were aged 25 – 34 years.

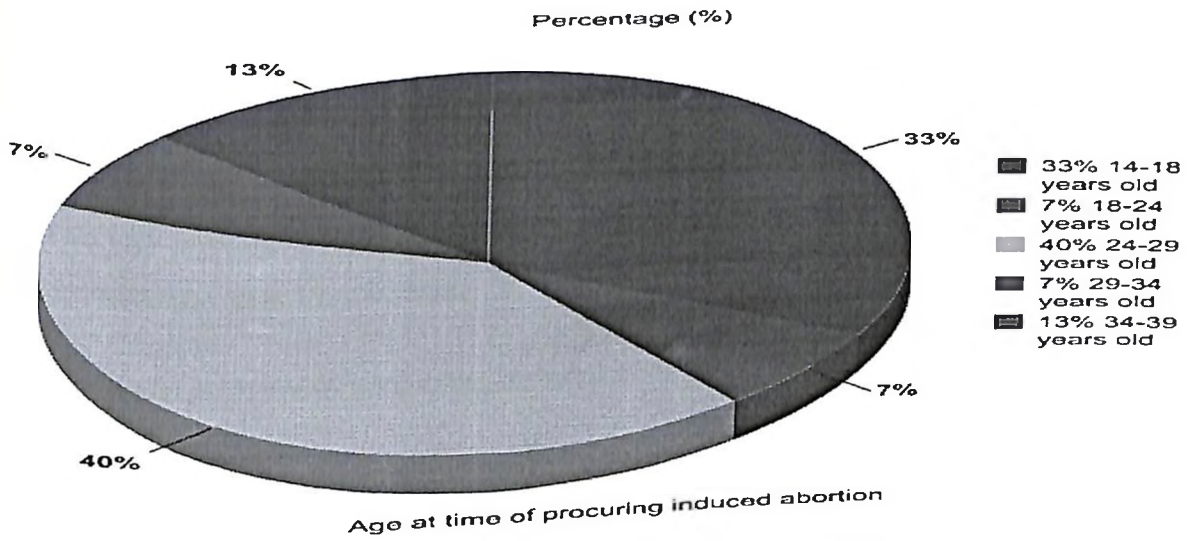

Figure 4.7: Age of informants at time of procuring first abortion

4.3.2 Duration of pregnancy preceding abortion.

The average duration of pregnancy preceding abortion was 2.8 months. Fifty-four per cent of the informants procured an induced abortion at 3 months, 33% at 2 months and 13% at 4 months (Figure 4.8). All the informants stated that they knew about their pregnancy on missing their following monthly period but it took them time to finally make the decision to procure an induced abortion.

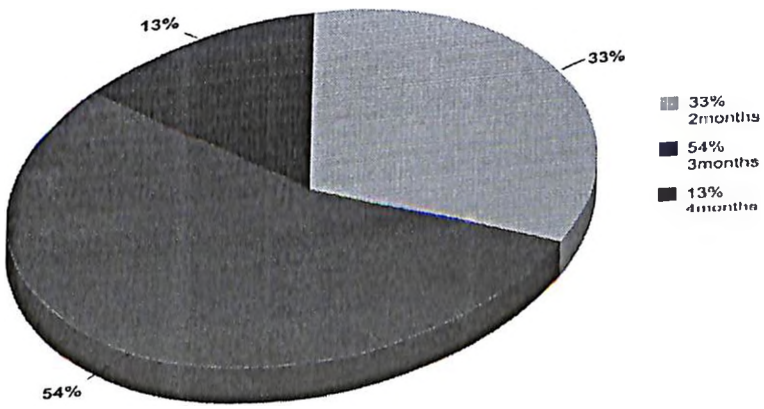

Figure 4.8: Duration of pregnancy preceding abortion.

4.3.3 Frequency of induced abortion.

Seventy-three per cent of the women had procured an induced abortion once in their life time, while 27% of the women had procured an induced abortion more than once. The second abortions took place between the ages of 25 – 29 years old, whilst the first induced abortion took place between the ages 14 -18 years.

4.3.4 Place and process of procuring induced abortion

Twenty per cent of the informants stated that they had procured an induced abortion at home, (27%) in clinics, while 53% used backstreet midwives presented in figure 4.9 below.

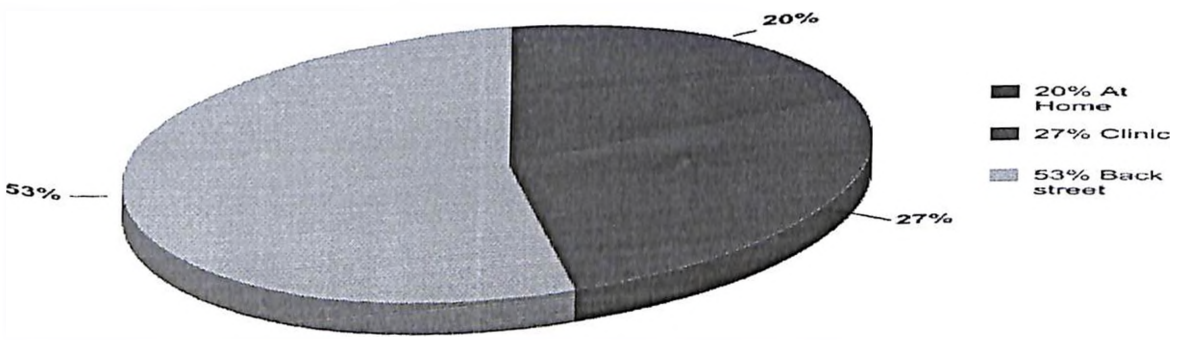

Figure 4.9: Place of procuring an induced abortion

Those who procured the abortion at home narrated that they went to a pharmacy and bought a drug that when they took, they experienced severe stomach pain after while, followed by profuse bleeding. The baby came out in form of blood. However, they could not state the type of drug either because it was prescribed by a friend and they could not remember the name or could not effectively pronounce it, or just chose not to reveal.

Those who went to the clinic described the experience as professional. They were given drugs to take, they experienced great pain when the baby was coming out but were later given painkillers. These informants believed it was a safe process and less risky.

The ones who went to backstreet midwives stated that they were prescribed for a mixture of concoctions and given a time to return to the midwife for the process to be complete. It could

take 12 – 48 hours of waiting. *'The process is very painful, the foetus comes out in blood and clots form'* described one of the informants. Some still feel the pain to date and suspect something might have gone wrong in their womb. One of the informants said it has been 3 years since she procured an induced abortion but still feels the pain and more so, wants to get another baby but has not been able to conceive.

4.4 Social aspects

4.4.1 Economic Instability

A majority (67%) of the informants confirmed the major reason for procuring an abortion was economic instability, none of them wanted to bring up a child they could not provide for. Box 1 below presents narrations on how economic instability influenced the informants' decision to procure an induced abortion.

Box 1: Testimonies on economic instability

Case 1: Angela (not her real name) 26 years old, separated from her husband and moved to Nairobi to seek employment.

'I got a boyfriend when I moved to live and work in Nairobi, he was still in college. When I told him that I was pregnant he said he was not ready to be a father and more so could not afford to bring up the baby as he was still in college and had no source of income. I really thought about his situation and the fact that I was also not able to take care of a second child. I have a daughter from my previous marriage and my mother who depend on me, they live in the village. My house maid salary could not support the three of us hence I made the decision to abort. It was an emotional moment and my boyfriend was equally distressed'.

Case 2: Amkaga (not her real name) 42 years old, married with 6 children.

'I reside in the village and I am small-scale farmer. On a a quarterly basis I visit my husband in Nairobi. Six years ago just when I had given birth to my last born, while she was still breast feeding I again conceived. This surprised me. I did not expect to be pregnant while breastfeeding. I had been informed that continuous breast feeding is a form of contraceptive, but

it turned out to be wrong. This was going to be our 7th child. My husband is a watchman, his earnings can hardly take care of us, in fact, more often than not, I have to send him food from the village and sometimes money from the proceeds of our farm produce, which are seasonal. All his salary goes to pay school fees for our son who is now in secondary school form 2. We also had two children sitting for their Kenya Certificate of Primary Education (KCPE) and who then, needed school fees when joining secondary school. My husband and I analysed our situation and agreed we cannot have another child. The last born had not even started crawling, it would have been strenuous to take care of a toddler and a new born baby. It would have also meant I stop working on the farm, which is a key source of family income. My sister took me to a clinic in the village where I procured the abortion. I feel sad about it but I am still convinced that was my only way out of the problem. Am also now more informed on prevention of pregnancy.'

A magistrate interviewed as a key informant, described the status of women who had been brought to his court for procuring an abortion, as a sorry state. He could not remember handling a case where the woman whose reasons for procuring an abortion were baseless. He also stated that economic instability is the most common reason in addition to desertion by the men responsible for the pregnancy. Some of the women had also been chased away from home for getting children out of wedlock. The magistrate reported that he has continuously been advised by reports from probation officers to draw his judgements. He has on several occasions found himself sentencing the women to community service monitored by probation officers. *'The situations described by probation officers are saddening, sentencing the women to imprisonment makes it worse, it's double punishment and does not benefit anyone. I don't think I have ever imprisoned such women,'* the magistrate explained.

4.4.2 Societal stigma and reaction by family members

Stigma and family response were the second most identified factors. These factors were intertwined with economic instability and insecurity.

4.4.2.1 Family rejection

Lack of family support or rejection increased the informants' decision to abort. Family set up and support are pillars of different individuals and when these pillars are broken, most women are left feeling hopeless. Box 2 below presents a narration by an informant on family rejection.

Box 2: Testimony on family rejection

Case 3: Mariam (not her real name) 20 years old.

'If my father had just accepted my pregnancy and not frustrated my mother and I, I would not have procured an abortion. I just needed assurance that my child would be supported. Today I regret, I feel so bad when I see ladies my age with 2 – 3 children. I wish I had my current job then. My father remains bitter with my mother and I. He even married a second wife whom he says will give him more disciplined children and children who are ready to go to school until they complete their studies without getting pregnant. I dropped out of school in form 1. My mother remains frustrated.'

4.4.2.2 Parental Coercion

Parents force their unmarried daughters to get an abortion in order to save face before the society and other relatives as narrated in box 3 below.

Box 3: Testimonies on parental coercion

Case 4: Addah (not real name) 19 years old.

'When I told my mother about my pregnancy, she immediately organized for my travel to Nairobi to live with her sister (my aunty). My mum and aunty thereafter took me to a clinic to procure an abortion. My mother later warned me not to ever talk about the incident. It was meant to be a secret. I was never given an option to express my wish. I actually could not give my opinion as I was still under the care of my parents hence they made the decisions. Apart from my mother, to date no one else in the immediate family knows about the incident, not even my father. My mother feared she could be labelled a failed mother. My then boyfriend was very upset; he

wondered why he was not consulted. He left me for this reason. Whenever I think about the incident I feel bad and regret that it happened.'

Case 5: Anyango (note real name) 18 years old.

'I dropped out of school after standard 8 exams due to lack of school fees. I came to live with my brother and his family here in Kibera. I met this man who promised to marry me. I got pregnant only to find out that he had another marriage with a wife and children living in the village. When I informed my family (mother, brother and sister-in-law), they all advised me to abort the child and to no longer date the man. They threatened that I would regret if I did not adhere to their advice. My mother emphasized that it is wrong to get married to an already married man, I must not be a second wife. I had to procure an abortion. My sister in law took me to the hospital. I still live with my brother, taking care of his children.'

4.4.2.3 Single mothers' syndrome

The societal censure against women who get pregnant out of wedlock creates an environment that makes women resort to procure an abortion. Single mothers are usually shunned by the society, seen as irresponsible and receive little support from the society. The fear of being rejected led some of informants to procure an induced abortion. Box 4 below presents a narration on fear of raising a child single handed and being labeled irresponsible.

Box 4: Testimony on single mothers' syndrome.

Case 6: Wambui (not her real name) 30 years old.

'I dated a man for two years. When I told him I was pregnant he accused me of infidelity, he denied that he was responsible and hence asked me to think of how I would manage the situation. We both attended the same church and were youth leaders. Most of the church members knew that my then boyfriend and I had a more special relationship. I thought he would marry me. I was not ready to face my pastor, church members and especially my parents. I feared being labelled a sinner, irresponsible or as I hear people say, a prostitute. I asked a friend for advise and she directed me to a clinic where I procured an abortion. I am no longer dating the man, he

betrayed me, he made me sin. I no longer go to the same church and to date, I strongly feel I offended God and do not deserve to be one of the faithfuls. At the point of procuring an abortion I was desperate to make things right, I didn't think of any other alternative. Today I really regret; I wish I could do things differently.'

4.4.3 Rejection or desertion by spouse/boyfriend

Rejection by men responsible for the pregnancy is one of the reasons that cause women to procure an induced abortion. Such men are usually not willing to settle down as parents or feel they are not in a position to support their existing family. Some husbands have ended up threatening their wives with dire consequences if they bore another child. In such cases, the women end up feeling insecure and fear that they would be deserted by their husbands if they remain adamant about continuing with the pregnancy (Guttmacher Institute, 1998). Some women who are already experiencing difficulties in their marriages or relationships are also driven to procure an abortion as they believe adding another child would escalate the problems already existing. Box 5 below presents narrations by informants on rejection by their spouse or boyfriend.

Box 5: Testimonies on rejection or desertion by spouse/boyfriend

Case 7: Sylvia (not real name) 28 years old, not married.

'I was born and brought up in the village. I dropped out of school while in form 2 due to a serious leg infection. My parents sent me to Nairobi to get support for treatment from my sister. I got better after one year of treatment, I did not go back to school; instead I got employed as a cleaner in one of the health organisation in Nairobi. My sister moved to live and work in the United States. I got myself a house in Kibera. I met this man who convinced me that he would marry me but immediately I announced I was pregnant he disappeared. Unfortunately my job also ended. For over 3 months I tried looking for the man to no avail. I could not go back home since I already had another child whom I got after primary school, standard 8. My parents would not approve of my actions, they remain disappointed that I did not finish school and I had a child out of wedlock, neither could I tell my sister.

I could not afford rent or food, the 3 months were hell. I begged for shelter and food from one friend to another while hoping to find the man who impregnated me. I soon discovered that my efforts were not bearing any fruits and the pregnancy was growing. I sold my phone for one thousand five hundred shillings (KES. 1,500) and used it to go to a pharmacy where I bought drugs to abort the baby. It is easier to stay hungry today on my own than when I was pregnant. I am now even able to do odd jobs just to make ends meet.'

Case 8: Onkoba (not her real name) 29 years old.

'When I told my husband that I was pregnant the first question he asked me was who was responsible for the pregnancy. This shocked me and annoyed me. He abused me while stating that he thought I was an educated woman, form 4 level, who should be able to think and use contraceptives. He warned me that if I dared to give birth to another child I should know where to take it. He said the two daughters we already have are enough and he needs no more children. My husband thereafter stopped supporting the family and showing the children and I love. Our home environment was unbearable, he even began drinking and coming home late. We would quarrel every day.

I finally decided I would abort the child as a compromise for peace in our home. When I asked him for the money to go to the clinic, he told me to find the money myself. He really did not want anything to do with the pregnancy. I finally managed to procure an abortion. Our home has gone back to normal, but my life will never be the same again. The aborted baby was a baby boy and I am not sure I will have another chance to get a boy child. It torments me when I think about it.'

4.4.4 Disruption of employment or source of income

Fear of losing employment and source of income is similarly a key reason for some women to make the decision to procure an abortion. Case 1 above, Angela, in addition to her concern of limited income, also had to struggle with the decision of losing her job as a house-maid. Her employer would not allow her to continue working while pregnant.

4.4.5. Disruption of education

Young women who get pregnant while in school have found themselves being forced to procure an abortion so as to proceed with their education. Cases 4 and 7 above are examples of young women who in their lifetime, were forced to procure an abortion so as to continue with their education. Such women comprised 13% of the informants.

4.4.6 Other socio-economic factors

These factors were identified during interviews with key informants and secondary sources. The information added value by explaining more factors that were not directly captured during primary data collection.

4.4.6.1 Incest and Rape

Women do not want to cope with the horror of the sexual violence or bear a child who would remind them of their gruesome past (Guttmacher Institute, 1998: 117). Counsellors interviewed expressed this factor as a common factor amongst young women aged 18 – 25 years. This observation is similar to that of a study by Guttmacher Institute (1998: 117) where the women stated that they did not want to bear children of people who were inhuman to them.

4.4.6.2 Failed contraceptive and limited knowledge on use of contraceptives

Women may feel the need to end an unwanted pregnancy that may have arisen due to failed contraception. Evidence abounds that a high proportion of women become pregnant unintentionally both in developed and developing countries (Guttmacher Institute, 1998:118). Contraceptive use does not necessarily provide complete protection against pregnancy, each method can fail (Guttmacher Institute, 1998:118).

One of the two interviewed doctors confirmed that none of the contraceptive methods is 100% perfect. However, with medical observation each woman can be given a contraceptive that suits her. '*It is also important that women get the correct information on their choice of contraception and avoid following myths around success or failure of contraceptives,*' said the doctor. Amkaga's narration (Box 1, Case 2) is a clear example of myths around contraceptive and

prevention of pregnancy. She believed that continuous breastfeeding would prevent her from getting pregnant. Some of the single women interviewed stated they feared using contraceptives before marriage as this would prevent them from getting children when they were ready. These are some of the myths disputed by the doctors interviewed. This information on limited knowledge on contraceptive use concurs with the 2008 – 2009 KDHS study which cited 53% consumption of contraceptives in Nairobi and lower percentages in other parts of the country (KNBS and ICF Macro, 2010).

4.5 Legal aspects

The study showed that 80% of the women interviewed had knowledge about the law against abortion at the time they made the decision to abort. The remaining 20% are those who procured an abortion when they were aged between 14 – 18 years and by the time of procuring the abortion they did not know the law. However, upon being adults or later in their lives and on sharing with friends, they learnt that abortion is illegal.

All (80%) of the women who knew about the law at point of procuring an induced abortion admitted that they had in mind the thought of being arrested and arraigned in court and mentioned varied sentences for the crimes. A majority said they knew the punishment was life imprisonment.

4.5.1 Influence of the law in decision-making

Notwithstanding the knowledge of the law and an idea of what the punishment would be, the law was not a crucial factor in the decision-making process; the frustrations experienced by the informants surpassed fear of the law. *'The problems are usually overwhelming, all you think about is how to end the problem, including death. Hardly do you think about the repercussion, more so the law. When the thought of illegality of abortion crossed my mind, I actually overrode it with the fact that abortion is a 50:50 chance. I could die or live to experience arrest,'* said one of the informants.

4.5.2 Perception of the law

Most (93%) of the women interviewed stated that women are increasingly becoming knowledgeable about the law against induced abortion. However, this scarcely influences their decision. Socio-economic challenges override the existence of the law. Some women felt the law had failed women in general. The law needs to shelter the women against the harsh socio-economic factors that force them to procure an induced abortion. *'The law is unfair, it should deal with truant fathers or boyfriends who reject women after impregnating them. The law should instead compel the men to be responsible for the mess they are part of,'* said one informant.

One of the counsellors interviewed stated that she knows that under her profession, she is obliged to inform her client on the provisions of the law, but based on the demeanor of the women, the law is hardly an issue they wish to discuss. All they want to know is the solution(s) to their predicament.

Amkaga, (Case 2 in Box 1), was confident that if the Government could provide simple and clear social mechanisms to support the women, many women would not consider induced abortion. For example, the law could provide practical solutions such as provision of homes for children who cannot be supported by their parents, support single mothers and provide free and quality health care, amongst other solutions. *'If I was certain about the help I can receive from my Government I would not have aborted. As a mother I would not like to live knowing my child is suffering, the law should give me that assurance and the Government must show action,'* she said.

The two perceptions were echoed by a social worker who expressed challenges when looking for placements for abandoned children or survivors of domestic violence. Children's homes owned by the Government are over-populated and half the time in a wretched state due to little or no resources (Echereria, 2010). Private children's homes, including those run by faith based organisations, have limited intake of children due to insufficient resources for the day-to-day running of the homes (Echereria, 2010).

One of the two doctors interviewed stated that abortion has largely been treated as a legal issue yet it is largely a medico - health issue and a woman's right issue. '*For the law to be effective, the medics' opinions and voices of women should take a key role in developing it,*' he said. The illegality of abortion remains a contested concern in society; there is no consensus. Cook et al. (2003) state that there is need for the law to protect the women from harmful and unsafe abortion. It should allow for provision of service for those who have conscientiously decided that they need the abortion service.

An advocate working with one of the women rights organisations, stated that Article 26(4) of the Kenyan Constitution, which permits abortion when advised by a trained health professional, when it is an emergency treatment or the life or health of the mother is in danger, is yet to be legislated. An act of parliament clearly giving guidelines on when a woman is allowed or not allowed to abort and provides clear mechanisms to track offenders, would be more effective than it is today.

Chapter Five

Discussions, Conclusion and Recommendations

5.1 Introduction

This chapter discusses the highlights of the social factors which influence women to procure an induced abortion and the extent to which the law influences the women's decisions. The chapter also summarizes the study findings and outlines suggested solutions to the problem. Finally the chapter draws a conclusion to the study and gives recommendations.

5.2 Key social factors that compel a woman to procure an induced abortion

There are probably as many reasons for induced abortions as there are women who have them. Most women, however, decide to have an abortion because the pregnancy represents a dilemma in their lives.

The study findings suggest that there are several social factors that influenced the decision of the study subjects to procure an induced abortion. During the decision-making process, these factors are considered but ultimately one of the factors, what the women consider major, carries the day. The study showed that the major and most common factor is economic instability. A majority of the informants (67%) stated they had insufficient financial resources and hence incapable to care for an infant, the care-giving needs of an extra child or even the first child. The informants' economic status was evaluated against their basic needs (shelter, food, and clothing) and the number of people who depended on them for these needs.

Society perception/stigma including single mothers' syndrome, rejection by spouse/boyfriend, parental coercion and family rejection was the second most identified factor though always intertwined with economic instability and insecurity. For example, a majority of the informants who were faced with family rejection or dissertation by spouse, explained that if they had a stable source of income they would not have succumbed to the societal stigma or perception, illustrated by case 3 box 2, where Miriam stated that if she had a source of income she would not

have procured an induced abortion and case 4, Box 3 where Addah illustrated that she regrets her action and wishes she had her own resources, the decision would have been different.

According to the Guttmacher Institute (1999), a handful of studies over the years have indicated consistently similar answers from women who identify why they've chosen to have an abortion. The top two reasons these women cite for not being able to continue their pregnancies and give birth are:

- Financial instability - many expectant mothers lack the resources to cover the staggeringly high costs associated with pregnancy, birth, and childrearing. Giving birth becomes a terrifying proposition for someone who lacks steady income or financial resources to continue the pregnancy.

- Relationship problems /unwillingness to be a single mother - a majority of women with unplanned pregnancies do not live with their partners or have committed relationships. These women realize that in all likelihood they will be raising their child as a single mother. Many are unwilling to take this big step due to lack of financial resources, interruption of education or career. Even in situations involving women cohabitating with their partners, the outlook for unmarried women as single mothers in discouraging.

The study also found that a majority of women (53%) who procure an induced abortion are single. This finding supports that by Guttmacher Institute (1999) and Baker and Khasiani (1992) who identified single women as being most prone to procuring an induced abortion. One reason for this is the fear of being stigmatized for getting pregnant out of wedlock and raising a child as a single parent.

When a woman decides to end an unwanted pregnancy she is exposed to the risks of unsafe and illegal abortion. In the alternative, when a woman carries an unwanted pregnancy to term there can be physical and mental health consequences as well as potential economic and social ramifications (WHO, 1997). For some women it's an inconceivable act, but for others abortion seems to be the only way out of an unplanned pregnancy and an impossible-to-negotiate future.

5.3 Extent to which the law influences a woman to procure or not procure an induced abortion

The study showed that all the informants who knew about the law at the time of procuring an induced abortion were not directed by the legal status of abortion. The law was not a crucial factor at the point of decision-making. The distress was overwhelming and surpassed thoughts about the law. The women also stated that the law had failed them by ignoring the circumstances surrounding procurement of abortions.

The continued use of induced abortion cannot be because the women are ignorant of the abortion law neither can it be attributed to the fact that women were protesting the law. A possible explanation for the observed negative correlation between abortion use and concurrence with the abortion law was the lack of social support system that would have enabled women to rationalize abortion use in the context of their needs and desires.

It is also clear that advocacy to liberalize abortion law will not really address stopping the act but will just address availability of safe abortion procedures and quality services for the management of post-abortion complications. There is still need to understand the underlying causes of abortion to stop the act, whether safe or unsafe.

5.4 The women's decision-making process

The study findings showed that women had a long list of socio-economic factors to consider. However, some of the common characteristics of the decision-making process were that not more than two factors comprised the key reason why the women decided to procure an abortion and none of the women had predetermined thoughts of aborting. The decision was not taken immediately after learning about the pregnancy; it took the women days to think through their options. This is reflected in the average age of the pregnancy at time of abortion, 2.8 months.

The process of decision-making and ultimately procuring an induced abortion is in itself traumatizing, not only to the women but also to the men responsible for the pregnancy. 33% of the women stated that upon sharing with their spouse/boyfriend about the pregnancy, the men either commenced to behave in weird manner, worry and express unwarranted harshness that

lead to domestic violence. Some men would equally regret and end up blaming the women regardless of the fact that they were initially against the pregnancy.

At the point of decision making the women feel they are caught between a rock and a hard place. The thought process tends to reflect Thomas Aquinas' principle of double effect (McIntyre, 2004:166) where a human being has to think through. Aquinas explained that if the good is slight and the evil great, the evil can hardly be called incidental. If there is any other way of getting a good effect without bad effect, this other way must be taken (McIntyre, 2004:166). The women have to deal with two "evils" to bring forth an unwanted baby and fail to take care of them causing them to suffer or to procure an induced abortion.

5.5 Role of service providers

On seeking the opinion of key informants the following comprised the answers on the role of service providers:

- Increase awareness on prevention of unwanted pregnancy which includes proper use of contraceptives, demystify the myths surrounding contraceptives and sex education.
- Sensitize citizens on the impact of abortion including the side effects and costs to the society.
- Be agents of change through actively participating in discussions and dialogues aimed at addressing abortion in the country. Expert opinion should be shared to arrive at practical solutions. The discourse should adopt a multi- stakeholder approach that includes experts from all relevant sectors, women's voices and allows the problems to be addressed holistically. The law cannot be made by the legal fraternity only.

5.6 Suggested solutions to the abortion problem

The solutions suggested by the target study population included:

- Positive socialization and upbringing of young males and females. There is need to teach children and the youth the value of responsibility, accountability and importance of respecting life. This would bring up an empowered generation and would minimize cases

of unwanted pregnancy, fear of taking up child bearing responsibilities and increase opportunity for dialogue when faced with challenges.

- Have supportive laws to address socio-economic challenges, for example, simple laws and procedures of adoption. Currently the law is complex, lengthy and has costly procedures.
- Increase affordability, accessibility and effectiveness of family planning. Every sexually active woman should be able to access suitable contraceptive for their bodies/health.
- To reduce the rate of abortion, the State/Government should provide strategic needs to women such as economic empowerment through means such as increased micro-finance, education including campaigns in school and representation in the decision-making fora. In some instances, the State/Government should be able to provide practical needs such as food, clothing and shelter for women under distress.
- Increase education and sensitization on the use of contraceptives. Currently, there are a few youth-friendly health facilities that enable the youth to actively participate in the education of family planning and discussion on sexuality. This can be replicated all over Kenya.
- Expand options in the law, describing instances when women can procure an induced abortion. Health of the woman should include her psycho-social health and not only physical health. For any law against abortion to be effective there is need for a system of tracking the offenders and bringing them to book.

5.7 Conclusion

The moral debate against abortion is of the opinion that no reason is quite enough for terminating a pregnancy. However, a majority of people are slowly recognizing that it is not the lack of love or femininity that drives women to decide against a pregnancy, and neither is abortion used as a form of contraceptive. The psychological effects of an abortion are sometimes far reaching and cause undue distress to the woman. It is therefore not just a matter of making abortion safe but need to reduce occurrence of induced abortion if not stop it.

From this study and other studies referenced herein, the law has continuously been the least factor that women consider when going through the decision making process on whether to procure an abortion or not. If at all, religious laws take priority over state laws.

5.8 Recommendations

Instead of reacting to the aftermath, and enhancing the criminalization of abortion, public resources should increasingly be used in the various, but well known means of prevention of unwanted pregnancies. It is clear that education is an important factor in determining the types of decisions that women make about unwanted pregnancy and induced abortion. Women need family life education to enable them to use contraceptives effectively for the prevention of unwanted pregnancy. The government must recognize the powerful role that education can play in ending this problem. The task is very huge, but there has to be a starting point, in this instance, advancing strategies for women economic and education empowerment would be a good place to start.

BIBLIOGRAPHY

African Union Commission (AUC) (2003). The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). African Union, Addis Ababa, Ethiopia. Available at http://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf . Accessed on 5/9/11

Baker, J. and Khasiani, S. (1991). Induced Abortion in Kenya: Case Histories. *Studies in Family Planning*, 23(1):34-44.

Baumgath P.W. and Regan J.R. (Eds) (1998). *Law, Morality and Politics*. Cambridge: Hacket Publishing Company.

Beijing Platform for Action (1995). Report of the Fourth World Conference on women in Beijing held from 4th to 15th September 1995. Available at nttp://www.un.org/womenwatch/daw/Beijing/platform. Accessed on 4/7/10.

Catholic Christian Article (2004). *Abortion and Excommunication*, Catholic Planet. Available at www.catholicplanet.com. Accessed on 24/10/10.

Central Bureau of Statistic, (CBS) (Kenya) 2010. *Kenya Demographic Health Survey 2009*, Nairobi, Government Printers.

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

Centre for Reproductive Rights (CRR) 2010. *In Harm's Way: The impact of Kenya's Restrictive Abortion Law*. New York: Centre for Reproductive Rights.

Centre for Reproductive Rights (CRR) and Association Des Juristes Maliennes (AJM) 2003. *Claiming our rights: Surviving Pregnancy and Child Birth in Mali*. New York: Centre for Reproductive Rights.

Centre for Reproductive Rights (CRR) and Federation of Women Lawyers Kenya (FIDA-K) 2007. *Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities*. New York: Centre for Reproductive Rights and FIDA (K).

Cook, J.R., M.B Dickens, and F.M Fathalla, (2003). *Reproductive Health and Human Rights: Integrating, Medicine, Ethics and Law*. Oxford and New York: Claredon Press.

Committee on Elimination of all Forms of Discrimination Against Women (1997). *Concluding Observations on the Report of Morocco Doc A/52/38/Rev*. New York. Available at http://www.unhchr.ch/tbs/doc.nsf. Accessed on 25/6/10.

Division of Reproductive Health (DRR) (2005). *Reproductive Health/Family Planning Policy Guidelines and Standards for Service Provider.* Nairobi: Regal Press Kenya.

Echereria D. (2010). *The Changing Landscape of Children's Homes.* Kitechild. Available at http://www.kitechild.org. Accessed on 11/11/11.

Family Health International (2004). Sample Focus Group Discussion and In-depth Interview Guides; Community awareness of and Barriers to longer – acting and permanent contraception. Available at http://www.maqweb.org/iudtoolkit/country_case/fgdguide.pdf. Accessed on 4/7/10.

Frankford_Nachmias, C. and Nachmias, D. (1996) *Research Methods in the Social Sciences*, 5th edn. London: St. Martin's press.

Google Earth (2011). Google Maps. Available at http://www.nationsonline.org/oneworld/map/google_map_Nairobi.htm. Accessed on 17/11/11.

Government of Kenya (1957). *Pharmacy and Poisons Act, Chapter 244 Laws of Kenya.* Nairobi: Government Printer.

Government of Kenya (1960). *Penal Code, Chapter 63 Laws of Kenya.* Nairobi: Government Printer.

Government of Kenya (1978). *Medical Practitioners Act, Chapter 253 Laws of Kenya.* Nairobi: Government Printer.

Government of Kenya (1996). *National Reproductive Health policy 1997 – 2010.* Nairobi: Government Printer.

Government of Kenya (2000). *National Policy on Gender and Development.* Nairobi: Government Printer.

Government of Kenya, (2001). *Children's Act No. 8 of 2001 Laws of Kenya.* Nairobi: Government Printer.

Government of Kenya (2003). *Kenya National Post-abortion Care Curriculum: Trainers Manual.* Nairobi: Government Printer.

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

Government of Kenya (2007). Vision 2030: *A competitive and prosperous Kenya.* Nairobi: Government Printer.

Government of Kenya (2007). *Kenya Reproductive Health/Family Planning Policy Guidelines and Standards, 2007.* Nairobi: Government Printer.

Government of Kenya (2010). *Constitution of Kenya.* Nairobi: Government Printer.

Gurumurthy, A. (1998*). Women's Rights and Status, Questions of Analysis and Measurements.* New York: UNDP.

Gutt, A. (1999). *Sharing Responsibility: Women, Society and Abortion Worldwide.* New York: Macher Institute.

Guttmacher Institute (1998). Reasons Why Women Have Induced Abortion: Evidence From 27 countries. 24 (3): 117 – 127 & 152. Available at http://www.guttmacher.org/pubs/journals/html Accessed on 11/11/11

Guttmacher Institute (2009). *Facts on Abortion in Kenya.* Brief issue. (4):2 Available at www.guttmacher.org Accessed on 10/11/11.

Guttmacher Institute (2008). *Unsafe Abortion in Kenya.* Available at http://www.consultations Africa.com/index.php?option. Accessed on 18/10/10.

Human Rights Committee (2006). *A Shadow Report on "Women's Reproductive Rights in the US."* New York: Centre for Rights.

Inter-Agency Forum on Marriage and the Rights of Women and Girls (1998). *Safe guarding the rights and dignity.* Available at http://www.forwarduk.org.uk/key. Accessed on 18/10/10.

International Bible Society (1984). *The Holy Bible: New International Version.* Zondervan, USA: International Bible Society.

International Projects Assitance Services (IPAS) 2003. *Magnitude of Abortion in Kenya.* Available at http://www.ipas.org. Accessed on 4/7/10.

Jackson, T. (1970). *Introduction to the Laws of Kenya.* Nairobi: East African Literature Bureau.

Jacobs, R. M. (2010:52-63). *The Principle of Double Effect.* MPA 8300: Villanova University. Leadership Ethics. Available at http://www83.homepage.villanova university.edu/richrad.jacobs/mpa/double effect.html. Accessed on 18/10/10.

Kenya National Bureau of Statistics (KNBS) 2010. *Economic Survey 2011 Highlights.* Nairobi: Government Printer.

Kenya National Bureau of Statistics (KNBS) and ICF Macro (2010). *Kenya Demographic and Health Survey, 2008-09.* Calverton, Maryland: KNBS and ICF Macro.

Kenya Medical Association, IPAS and Federation of Women Lawyers (2002). *Reproductive Rights in Kenya: From Reality to Action.* Nairobi: Noel Creative Media.

King, P. (1991). Jeliping Women Helping Children: Drug Policy and Future Generations, *Milbank Quarterly*,69 (4): 595-621.

League of Kenya Women Voters (2005). *CEDAW and Beijing Platform for Action Simplified.* Nairobi: League of Kenya Women Voters.

McIntyre, Allison (2004). Doctrine of Double Effect. *In Stanford Encyclopedia of Philosophy.* Edward N. Zalta (ed).pp. 165 – 166. Revised on Monday 29th June 2009. Available at http://plato/Stanford.edu/achieves/fall2009/entries/double effect/. Accessed on 5/9/11.

MedicineNet.Com doctors (2008). *Webster's New World Medical Dictionary*, 3rd edition. New York: Wiley Publishing. Available at www.medterms.com. Accessed on 22/10/10.

Nyoike, M. (2007). *Legalize Abortion in Kenya.* Paper presented by graduate student at the John Kennedy School of Government at Harvard University, 2nd July 2007.

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

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

Ouma, A. J. and A. van der Kwaak (2009). *Promoting Sexual Health for Young People in Kenya: The Family Health Options Kenya Sexuality Counselling Approach.* Amsterdam: KIT.

Organization Panamericana de la salud, UNFPA & UNIFEM (2007). *Gender Health and Development in the America's: Basic indicators.* Washington, D.C: PAHO, UNFPA, UNIFEM.

Pope Pius XI. (1930). *Encyclical Letter on Christian Marriage,* The Human Body: Papal Teachings, 1960 pp. 31 -34, in Sources p.35

Republic of South Africa (RSA) (2008). *Choice of Termination of Pregnancy Amendment Act 1 of 2008.* Pretoria: Government Printing Works.

Republic of South Africa (RSA) (1996). *Choice of Termination of Pregnancy Act.* Pretoria: Government Printing Works.

Sedgh G. (2007). Induced Abortion; Estimates rates and trends worldwide, Lancet 370 (9595). Available at http://www.thelancet.com/journals/lancent/article. Accessed on 4/7/10.

Singson S. (2010). Catholic family and Human Rights Institution, Competing views on maternal mortality reduction clash at Beijing +15, Vol. 13, No. 13 Available at http://www.lifenews.com Accessed on 24/10/10.

Solomon, D. "Double Effect," *The Encyclopedia of Ethics* available at http://www.saintmarys.edu/incandel/doubleeffect.html. Accessed on 4/7/10.

South Africa High Court (1998). *Transvaal Provincial Division Case. No. 1629/97 (1) BCLR 1434 (T) (199) (3) LRC 203).*Pretoria: Government printing Works.

Terrence, J.D. (2010). Lifesitenews.com: New report by American Law firm Pushes for Abortion in Kenya. Available at http://www.lifesitenews.com/news/archive/ldn/2010/mar/10032510. Accessed on 5/7/10.

Tobes, B. (2001) "The Right to Health" in Asbjorn Eide, Catarina Krause and Allan Rosas (eds), *Economic, Social and cultural rights* 2nd Revised Edition, Dordrecht Netherlands, Martinus Nijhoff publishers

UN Convention on the Elimination of all forms of Discrimination against Women; CEDAW (1979)

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

Vardy, P. (1999). *The Puzzle of Ethics.* Available at http://www.rsrevision.com/ Accessed on 18/10/10.

World Bank (2007). *Global monitoring Report, Millennium Development Goals, Confronting the challenges of Gender Equality and fragile States.* Washington, DC: World Bank.

Women's Environment & Development Organization (2005), *Beijing Betrayed*, Women Worldwide Report That Governments' Have Failed to Turn The Platform Into Action, Astoria Graphic, New York, USA.

WHO (1992). Recent Advances in Medically – Assisted Conception: Report of WHO Scientific Group. WHO Technical Report series 820. Geneva: WHO.

WHO (1997). *Violence Agaisnt Women Health Consequences.* Available at http://www.who.int/gender/violence/en/us.pdf. Accessed on 22/10/10.

WHO, UNICEF & UNFPA (2000). *Maternal Mortality Estimates.* Geneva: WHO, UNICEF & UNFPA. Available at http://www.reliefweb.in/library/documents/2003/who-saf-22oct.pdf. Accessed on 6/7/10.

Appendix 1: In-Depth Interview Guide

My name is Teresa Omondi a master of art student at the university of Nairobi undertaking a research on the Social and legal aspects that influence abortion in Kenya. The purpose of the study is to explore the social factors that influence a woman's decision to procure an induced abortion and examine to what extent the legal status of abortion influences a woman to procure or not procure an induced abortion.

With your permission, I will be asking you questions regarding your encounter with induced abortion. I will also request that you allow me to write the answers and key ideas you provide.

I assure you that all discussions made shall be treated with utmost confidentiality. Your identity will remain anonymous. This interview will take approximately 45 minutes.

(Pause to seek consent and signing of consent)

I..... agree to be interviewed for purposes of the aforestated research.

Signature..... Date .....

ID Code ..... Interviewer .....

Biodata

1. Area of Resident_____

2. Age of informant (Please mark (X) one option).

18 - 27	( )
28 – 37	( )
38 – 47	( )

48 and above ( )

3. Occupation of informant_____

4. Highest Educational Level attained (Please mark (X) one option).

Post-Graduate ( )
Graduate ( )
Secondary ( )
Primary ( )
None ( )
Any other (Please specify) _____

4. Marital Status (Please mark (X) one option).

Married ( )
Single ( )
Widowed ( )
Divorced ( )
Separated ( )
Any other (Please specify) _____

5. Number of Children: Girls _____ Boys _____

6. Number of Dependants: Girls _____ Boys _____

Information on Abortion

Social factors

1. Please give a description of when you procured and induced abortion, how many times, where and by whom (for example, medical practitioner, home based)?
2. What would you describe as your major reason(s) for procuring the abortion? (Possible probes on religion, culture, economic status, marital status, legal, family/friends influence)

3. Did you share with your experience with another person(s)? What was their reaction? (Expound)
4. Is this an experience you would talk about openly and/or publicly)?
   a. If yes with whom or in what circumstances.
   b. If No, explain reasons
5. Kindly describe if you had any other alternative(s) at point of making your decisions to abort?
   a. If yes, what was the alternative(s)? Why were they not considered
   b. If No, explain the circumstances at point of making the decision.
6. What is your perception on society's view on a woman who has procured an abortion? Are there discriminatory practices? (Expound)

Legal status

7. Abortion remains illegal in Kenya; what is your opinion about this law?
8. Did this law influence your decision? Why?
9. Kindly tell me if you were put in the same situation how different would you handle the situation? Why? (Possible probes on social factors and whether legal status of abortion would influence decision?
10. What is your suggested means of ending this problem? Role of women in seeking solutions
11. Any other comment
12. Please tell me which other woman I can speak to (Explain reason for the request and the criteria of next informant)

Thank you so much for your time and agreeing to participate in this interview.

Appendix 2: Key Informant Interview Guide

Profession: ..... Sex: .....

Years of work experience: .....

Information on Abortion

1. Kindly describe your encounter with a woman who has procured an induced abortion. (Possible probes on frequency of encounter, level of engagement with the situation).

2. What are the common/major reasons given by the woman for her decision? At what point of engagement do they provide these reasons?

3. In your opinion do these women have an alternative to abortion? Please expound.

4. What would you describe as the impact of abortion on these women?

5. How would you rate the success of the abortion law in Kenya? How does it impact on women's decision to or not to procure an induced abortion?

6. How do you evaluate the role of your profession and other professions in addressing this problem? Any solutions?

7. What are the possible solutions to the problem? What resources are needed to address the problem?

8. Any other comment.

Thank you so much for your time and agreeing to participate in this interview.

Appendix 3: Guide for Case Narratives

(Introduction and bio – data similar to that of In-depth interview guide)

Information on abortion

1. Please give an account of your experience on procurement of induced abortion. (Possible probes on when she knew of the pregnancy, process of decision making and procurement of the abortion – when, where, by whom. How many times has she procured an induced abortion. Key factors that influenced their decision; religion, culture, economic status, marital status, legal, family/friends influence). Allow Narration.

2. How has the experience impacted your life and what are your suggested solutions to this problem?

3. Any other information you would like me to know?

4. Please tell me which other woman I can speak to (Explain reason for the request and the criteria of next informant)

Thank you so much for your time and agreeing to participate in this interview.