

**ACCESS TO SAFE ABORTION SERVICES IN KIBERA INFORMAL
SETTLEMENTS, NAIROBI CITY COUNTY, KENYA**

BY

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**A THESIS SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY,
GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN
MEDICAL ANTHROPOLOGY OF THE UNIVERSITY OF NAIROBI**

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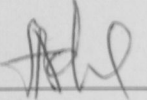


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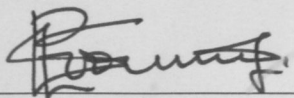
Declaration

I hereby declare that the work in this thesis is entirely my own work and it has not been presented anywhere for the award of any degree.

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This thesis has been submitted for examination with my approval as the university supervisor.

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Prof. W. Onyango Ouma

Dedication

This study is dedicated to my family and my son Myles Austin Abuodha. They have been a great source of motivation and inspiration throughout my research work.

My sincere gratitude goes to my supervisor, Dr. [Name], for his guidance, support, and constructive criticism throughout the writing of this thesis. He also inspired me to conduct ever-better research.

My sincere gratitude goes to all staff of the Institute of Anthropology, Gender and African Studies at the University of Nairobi, for their support throughout my Master's program in general and in particular in this thesis for having contributed their knowledge.

Special thanks go to my Mum, Mrs. Lilian Bogire for her confidence in me since I was very young. Her support and encouragement inspired me to work hard. I also wish to sincerely thank my sisters and brothers (Emily, Helen, Violet, Denis and Cyrus) who are always just a call away for their encouragement and support especially during critical points when the road seemed rough. I also heartily thank my informants for their co-operation and willingness in giving all private and secret information for the fulfillment of this study.

Last but not least, I am highly indebted to The University of Nairobi for awarding me a full scholarship for my Master's program. All these would not have happened without the University's support.

Thank you all.

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Abstract

This thesis focused on access to safe abortion services in Kibera informal settlements in Nairobi City County. The main objective of the study was to explore the factors influencing access to safe abortion services in Kibera informal settlements. The specific objectives were to investigate the women's understanding of the abortion provisions in the Kenyan constitution; to determine the availability and accessibility of safe abortion services in Kibera informal settlements and to examine how women's attitudes influence their access to available abortion services in Kibera informal settlements.

The study design was cross-sectional, combining both qualitative and quantitative methods of data collection. The qualitative methods that were used included case studies, focused group discussions and key informants interviews. Quantitative data was collected in a survey using a semi-structured questionnaire. Non-probability sampling methods were used to draw the study participants. A total of 50 women of reproductive age (15-49 years) were sampled to participate in the study using convenience sampling technique. These women participated in the survey. Three (3) FGDs were conducted with a sub-sample of the women who had participated in the survey. The focus group participants were conveniently selected on the basis of who had time to participate in the discussion. Key informants were selected purposively and case studies were drawn using the snow-ball technique. Data were analyzed using different techniques. Qualitative data was analyzed using content analysis whereby; data was read and re-read to identify the main themes related to the study objectives. Narrative and verbatim quotations were used to explain the trends exhaustively. Quantitative data was analyzed by SPSS version 21.

The findings suggested that majority of the women in Kibera (80%) were not aware of what the constitution says about abortion in Kenya. All they said was that abortion was illegal from both the state and religious perspectives. The study found out that lack of adequate health facilities that offered safe abortion services and the high cost of safe abortion in Kibera drove women to procure unsafe abortions from unqualified providers. The study also revealed that women's attitudes towards abortion influenced their practices; women who viewed abortion as a sin were against abortion (safe or unsafe abortion). For others, the stigma that is associated with abortions in Kibera made them to procure unsafe abortions from backstreet providers. Women who suffered a lot of pain from unsafe abortions reported that they would only procure abortions from safe providers in the future.

It is concluded that that lack of knowledge on the provisions of the constitution on abortion in Kenya is a barrier for most women and girls in Kibera who want to terminate their pregnancies safely. Few healthcare providers are knowledgeable on the full content of the law and most women remain unaware of provisions of the law. A lack of clarity about legal access to abortion has produced widespread misinformation among women, adolescents, and medical providers. In addition, women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe abortion services.

This study recommends that there is need to create more awareness among public on what the constitution says about abortion and especially women need to be educated on their rights and the legal issues around abortion. The government should ensure that there are sufficient facilities that offer safe abortion services to women (both public and private) and to ensure that the cost of safe abortion is affordable to women.

Abbreviations and Acronyms

APHRC-African Population and Health Research Centre

CRR- Centre for Reproductive Rights

D&E- Dilation and Evacuation

EVA- Electric Vacuum Aspiration

FGD- Focus Group Discussion

KDHS-Kenya Demographic and Health Survey

KHRC-Kenya Human Rights Commission

KNBS- Kenya National Bureau of Statistics

MDG- Millennium Development Goal

MVA- Manual Vacuum Aspiration

NCAPD- National Coordinating Agency for Population and Development

NCLR- National Council for Law Reporting

RH-Reproductive Health

SAC- Safe Abortion Care

SAS- Safe Abortion Services

UNDP- United Nations Development Programme

WHO- World Health Organization

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Unsafe abortion is defined by the WHO as a procedure for terminating pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO 2011:2). Worldwide, unsafe abortion persists as a serious and continuing public health challenge (WHO 2011:17, WHO 2003). It accounts for 13% of global maternal deaths and remains the principal cause of a range of short-and long-term health complications in women (Khan *et al.* 2006).

Over the past two decades, the health evidence technologies and human rights rationale for providing safe, comprehensive abortion services have evolved greatly. However, an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47,000 women and disability for an additional 5 million women (WHO 2011:17). Annually, it is estimated about 80, 000 worldwide deaths from unsafe abortions occurs, over 99% of these deaths occur in the developing countries of sub-Saharan Africa, Central and Southeast Asia, and Latin America and the Caribbean (Grimes *et al.* 2006:1908).

In Kenya, a woman has a one in 55 chances of dying from pregnancy related causes over her lifetime, and about 360 women die per every 100,000 live births (APHRC 2012). Approximately 35% of Kenya's maternal deaths are caused by unsafe abortions. An estimated 800 abortions, induced or unprompted, occur on a daily basis in Kenya, and over 2,600 women in Kenya die due to unsafe abortion practices annually.

Unsafe abortion in Kenya has long been recognized as a leading cause of maternal morbidity and mortality (Solo 2001:20). The major contributor to unsafe abortions is unintended pregnancy, not only in Kenya but also in the whole of Africa (Gage 1996, Magadi 2006). In Kenya, the prevalence of unintended pregnancy remains high. The 2008-09 Demographic and Health Survey (DHS) shows that 43 % of births were unintended (17 % were unwanted and 26 % were mistimed) (KNBS 2010).

Recent studies that have focussed on the magnitude and complications of abortion in Kenya found that about 20,000 women annually sought medical care for abortion-related complications in public sector hospitals alone (Gebreselassie 2005:1229). The treatment of abortion-related complications in public hospitals consumes a lot of resources, including hospital beds, blood supply, medications, and often operating theatres, anaesthesia and medical specialists (Gebreselassie 2005, Nzioka 2009). Incomplete abortions also account for a large proportion of gynaecological admissions in public health facilities.

The MDG 5 aims at improving maternal health by reducing maternal mortality and morbidity. However, the goal may not be attainable due to higher rates of deaths and injuries related to unsafe abortion (NCAPD 2010). Tackling unsafe abortion is thus key to the country's attainment of MDG 5 (Oyieke *et al.* 2006:4). Improved access to high-quality comprehensive abortion care which includes availability of safe abortion services, accessibility, affordability and acceptability of safe abortion services, rapid and accessible treatment of incomplete abortions and other complications, contraceptive and family planning services, and other reproductive health services at all levels of the country's health system; will not only save lives but also reduce costs to the health system (Shaw and Elmendorf 1994).

The new constitution of Kenya (2010) provides stronger protection for the lives and health of women. It explicitly permits abortion when “in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the pregnant woman is in danger, or if permitted by any other written law” (NCLR and CRR 2010). The constitution also states that “a person shall not be denied emergency treatment” (NCLR 2010). Generally, the new constitution provides a new legal foundation for women’s access to safe abortion and is the basis for the Standards and Guidelines for Reduction of Morbidity and Mortality from Unsafe Abortion in Kenya recently developed by the Ministry of Health (CRR 2010).

For the purposes of this study, abortion safety includes not only the physical safety of women, as promoted by access to competent operators and appropriate facilities (WHO, 2011), but must also protect the psycho-social safety of women undergoing the procedure, as promoted by respectful and humane abortion care attitudes and practices of professional caregivers (Slade *et al.* 2001). Psycho-social safety in abortion care is less dependent on what technical care is delivered than on “the way care should be delivered” (Slade *et al.* 2001: 72) and “the quality of care received from staff” (Slade *et al.* 2001:72). Thus, although their physical safety may be protected, women who access technically appropriate abortion services but receive them in dehumanizing or demeaning ways do not access safe abortion services as their psychological safety remains at risk. This study explored the factors influencing access to safe abortion services; which entailed availability, accessibility, affordability and acceptability of safe abortion services using anthropological research techniques.

1.2 Statement of the problem

In 2010, Kenya adopted a new constitution that provides stronger protection for the lives and health of women (NCLR 2010). Initially, the law only allowed abortion to protect the pregnant woman's life. Article 26 (4) of the new constitution explicitly 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 (NCLR 2010). However, despite the provisions in the law, desperate women continue to self-induce abortions or obtain clandestine abortions carried out by untrained persons under poor hygienic conditions. Of concern is, why a large number of women still procure unsafe abortions from unqualified providers, yet, the law provides for safe abortion services when 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 (NCLR 2010).

Recent statistics in Kenya show that many women procure abortion using clandestine methods and this has brought about high morbidity and mortality rates. A recent survey (APHRC 2012) showed that 464,690 abortions were procured in 2012, and nearly 120,000 women sought treatment for complications arising from unsafe abortions, while three-quarters needed treatment for moderate or severe complications, including high fever, sepsis, shock, or organ failure. Most of them were married women while girls as young as 10 were also captured in the survey data (APHRC 2012).

Qualitative studies (CRR 2010, APHRC 2012) show that Kenyan women commonly obtain abortions using unsafe methods and unqualified providers. Some of the reasons that have been put forward to account for the high unsafe abortion rates in Kenya include high

restrictive law, inability to pay for safe abortion services due to poverty, inaccessibility of health service, unavailability of safe abortion services, provider's negative attitudes, poor quality of services; and social, cultural, economic and religious pressures (APHRC 2012, CRR 2010).

In sum, there is need to generate evidence on the factors influencing access to safe abortion services in order to address gaps in the delivery of comprehensive abortion services as well as inform advocacy campaigns on abortion and thereby reduce unsafe abortions in Kenya.

This study endeavoured to answer the following questions:

- i. What are the provisions of the constitution on abortion and do women understand these provisions?
- ii. Are safe abortion services available and accessible in Kibera informal settlements?
- iii. How do women's attitudes towards abortion influence their access to available abortion services in Kibera informal settlements?

1.3 Research Objectives

1.3.1 General Objective

To explore the factors influencing access to safe abortion services in Kibera informal settlements.

1.3.2 Specific Objective

- i. To establish the women's understanding of the provisions regarding abortion in the Kenyan constitution
- ii. To examine the availability and accessibility of safe abortion services in Kibera informal settlements
- iii. To assess how women's attitudes towards abortion influence their access to available abortion services in Kibera informal settlements

1.4 Assumptions

- i. Women's understanding of the provisions regarding abortion in the Kenyan constitution influences their decisions and choices on abortion
- ii. Unavailability and inaccessibility of safe abortion services in Kibera informal settlements compel women to procure unsafe abortions
- iii. Women's attitudes towards abortion influence their access to available abortion services in Kibera informal settlements

1.5 Justification of the study

Studies by APHRC (2012), shows that one of the major causes of maternal morbidity and mortality is unsafe abortion. Thus, if the trend continues, Kenya will not achieve its MDG goal 5 of improving maternal health. This study sought to generate useful insights that can be used by the government and non-governmental organization to promote and improve access

to safe abortion services in Kenya and hence, help in the reduction of maternal morbidity and mortality.

This study also sought to provide important information for women's advocacy campaigns on reproduction, sexuality and personal rights that will enable women understand their rights and hence make informed choices in relation to termination of pregnancy, thereby, improving maternal health.

This study further sought to offer useful recommendations that will contribute to the future development of this line of research, particularly in a developing country like Kenya. Thus, this study is important not only to practitioners, policy makers and implementers but also to future researchers.

1.6 Scope and Limitations of the study

This study focused on the factors influencing access to safe abortion services in Kibera informal settlements by looking at the women's understanding of the constitutional provisions regarding abortion in Kenya, the availability and accessibility of safe abortion services and women's attitudes towards abortion and how it influenced their access to available abortion services in Kibera informal settlements. The study was limited to Kibera informal settlements and it targeted women of reproductive age (15-49) years.

The major limitation of this study was that abortion being a very sensitive topic and due to a lot of societal stigma associated with it, it was difficult to get women who had procured an abortion to freely share their stories. However, a good rapport with the women in the initial stages of the study helped them to open up and shared their stories freely.

Another limitation that arose was that girls and women who provided information about induced abortion were only selected from a few organizations. The small sample size constrained generalizability. However, due to well formulated research instruments, valid data was still gathered.

1.7 Definition of Key Terms

Abortion- is the termination of pregnancy before the foetus is viable

Safe abortion- refers to both physically and psycho-social appropriate abortion services

Unsafe abortion- is a procedure for terminating pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both

Access- encompasses availability, affordability, reachability, and acceptability of safe abortion services

Availability- Presence of safe abortion services

Affordability- cost of safe abortion services that is within one's financial means

Reachability— able to get to facilities that offer safe abortion services

Demand for abortion services- encompasses women's knowledge of safe abortion services, attitudes toward seeking the services and confidence in obtaining services

Supply for abortion services- includes access to abortion care, service quality and providers attitudes towards abortion

Phenomenology - the scientific study of experience that attempts to explain human consciousness in its lived immediacy

Attitude-a way of thinking or feeling about abortion both by the women demanding abortion services and the providers supplying abortion services

Women of reproductive age- women in the age bracket of 15-49 years

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section gives a general overview of abortion laws and practices in many parts of the world as well as in Kenya. The literature tackles the issue of unsafe abortion in Kenya; Availability of safe abortion services in Kenya, cost of abortion services as well as the beliefs and attitudes towards abortion. Finally, the section describes the theoretical framework that guided the study.

2.2 General Abortion laws and practices

The abortion law is full of widely varied enforcements by most countries all over the world. Even within the same country, different political parties can have different opinions on abortion, and laws that involve abortion as it is a highly sensitive issue. For example, countries like Mexico, Nigeria and to some extent the United Kingdom had different political parties with different views regarding abortion laws (UNDESA 2007).

The 2008 annual report of the Centre for Reproductive Rights indicated that at least 26% of world citizens live in countries where abortion is prohibited (CRR 2008). Currently, most countries, even those with relatively liberal laws on abortion, still have penal code provisions that indicate the situations in which abortion is a crime (Goodman *et al.* 2008). In addition; laws, policies, economic status, culture and social norms strongly influence women's choices when undertaking abortion, and especially unsafe abortion (CRR 2008).

There are no universal abortion laws that protect women's life and provide the right to safe abortion care. The possible reasons for this could be due to not practicing the safe abortion law even though, it declares without exceptions SAC services to a pregnant woman. Furthermore, there is some people interpret the law narrowly in order to deny women services; for instance, different country law makers and pro-abortionists argue whether the law that says "abortion is legal when it is necessary to protect a woman's health"; includes or should include woman's mental health. Other countries still exercise the laws implemented by their former colonizers regardless of the staggering rises of maternal morbidity and mortality (WHO 2006).

Approximately, one fourth of the world's 7 billion people live in countries where abortion law is prohibited or where it is permitted only to preserve the physical and mental health of the woman. In the Middle East, most of the countries, almost two thirds of the countries of Latin America, a majority of the countries of Africa have a restrictive abortion law (WHO 2004). Abortion on broader medical grounds is used to avert a threat to the woman's physical health rather than to her life, known genetic or other impairment of the fetus or juridical indication (e.g. rape, incest). In the rest of the countries, the law permits abortion to save the woman's life. One-third of countries allow abortion on economic or social grounds, and at least one-quarter allow abortion on request. Thus, all countries should have accessible and safe services in place to provide abortion where the law permits (Finer *et al.* 2000:6).

Restrictive abortion laws can create huge disparities among abortion-seeking individuals of a community. Studies in countries with such laws has shown that women that can afford it, often find a private physician, nurse, or midwife willing to perform a safe abortion while women who cannot afford or access services may end up experiencing unsafe practices mostly by unskilled practitioners (Berer 2004:3). Legalization in itself, does not guarantee the required care.

2.2.1 Abortion laws in Kenya

In 2010, Kenya adopted a new constitution that provides stronger protection for the lives and health of women (NCLR 2010). Whereas the prior law only allowed abortion to protect the pregnant woman's life, the new constitution in article 26, section 4, explicitly permits abortion on the following grounds; where there is need for emergency treatment to preserve the life of the pregnant woman and/or the fetus, where the pregnancy constitutes danger to the life of the pregnant woman, where the pregnancy constitutes danger to the health of the pregnant woman or where is permitted by any other law (NCLR 2010).

Article 43 (1) (a) further widens access to reproductive health rights including access to safe abortion -Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care (NCLR 2010). The constitution also states that "a person shall not be denied emergency treatment" (NCLR 2010).

However, it is unclear how widely the new abortion law is understood or practiced within the medical community. Furthermore, sections of the Kenyan penal code have not been revised to reflect the language of the new law, and medical providers may be reluctant to perform abortion arising from any cause for fear of legal consequences, even though these penalties do not apply to the provision of legal abortions (NCLR 2009). The Kenyan penal code currently lists self-inducing abortion, or providing any other type of "unlawful" abortion, as felonies punishable by a 7–14-year prison sentence.

The restrictive provisions of abortion in Kenya have not curtailed abortion but have instead driven this practice underground. Many procedures are conducted under unsafe and

unhygienic conditions and carry a substantial risk of maternal morbidity and mortality (APHRC 2012).

2.3 Unsafe abortions in Kenya

Restrictions to safe and legal abortion have the observed effect of driving women to procure unsafe abortions which have myriad side effects requiring post-abortion care. Clandestine abortions are usually performed without anaesthesia and in unsanitary environments. Women are also locked out from new and safer abortion techniques (Nyanjom 2007).

Unsafe abortion procedures in Kenya may involve insertion of an object or substance (root, twig, or catheter or traditional concoction) into the uterus; dilatation and curettage performed incorrectly by an unskilled provider; ingestion of harmful substances; and application of external force (APHRC 2012). In some settings, traditional practitioners vigorously pummel the woman's lower abdomen to disrupt the pregnancy, which can cause the uterus to rupture, killing the woman (WHO 2011, CRR 2010).

Complications of unsafe abortion include haemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. About 20-30% of unsafe abortion cause reproductive tract infections and 20-40% of these result in infection of the upper genital tract (WHO 2004). One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability requiring medical care (Singh 2006).

In 2002, a national estimate of abortion in Kenya was recorded from a study of women treated for post abortion complications. According to that study, more than 300,000 abortions

occur in Kenya annually; that translates to 46 abortions for every 1,000 women of reproductive age (APHRC 2002).

Currently, the rate of unsafe abortion in Kenya is higher when compared to that of 2002. A recent national estimate study on unsafe abortion (APHRC 2012) indicates that an estimated 464,690 induced abortions occurred in 2012, corresponding to an induced abortion rate of 48 abortions per 1000 women of reproductive age (15-49 years), and an induced abortion ratio of 30 abortions per 100 births in 2012. It also estimated that 157,762 women received care for complications of induced and spontaneous abortions in health facilities in the same year. Of these, 119,912 were experiencing complications of induced abortions. About 23% of the women who presented for post-abortion care presented with mild complications, 40% with moderately severe and 37% with severe complications such as high fever, sepsis, shock, or organ failure (APRHC 2012).

Furthermore, an estimation of 266 Kenyan women die per 100,000 unsafe abortions. When compared to other countries in East Africa where similar data have been gathered, Kenya's rates of induced abortion, proportion of abortion complications categorized as severe, and the abortion complication fatality rate remain disproportionately high. There is also evidence that while the use of MVA/EVA and medical abortion is growing in Kenya, other less safe procedures such as D&C and digital evacuation remain widespread, suggesting critical inequities in Kenya in the availability of basic essentials for high quality post abortion care and safe induced abortion (APHRC 2012).

Induced abortions are not occurring at the same rate throughout the country. High rates of abortion were seen in Nyanza-Western region and in the Rift Valley region, compared to other regions in the country. These higher rates could be attributed to poor women's health,

higher poverty levels, gender-based violence, and poorer access to family planning services in these regions. The high incidence of abortion is related to high levels of unintended pregnancy (Ipas Alliance Africa 2012).

However, because abortion is highly restricted and stigmatized in Kenya, measuring abortion levels is challenging, and underreporting is common. A 2009–2010 study conducted in four poor urban settlements in Nairobi asked women about pregnancy and pregnancy loss. Of the 200 women who had experienced a pregnancy loss, fewer than 4% characterized it as a voluntary termination, and the vast majority (80%) reported that they had had a miscarriage (Ochako and Izugbara 2011).

2.4 Availability and accessibility of safe abortion services in Kenya

Women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe abortion services. Although Kenyan women with financial means usually have access to relatively safe abortions performed by private practitioners, most poor women must resort to unsafe and clandestine means. (Rebecca and Bernard 1981).

Women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya's public healthcare system. The limited number of healthcare providers trained to perform abortions also dramatically restricts women's access to safe abortion services—and magnifies concerns about provider barriers to access, given that few providers are able to offer services (CRR 2010). Often, there may be no trained abortion providers on staff when a woman arrives at a healthcare facility. To obtain a safe abortion, women must typically be referred to

another healthcare facility where there is a trained provider on staff, creating logistical hurdles and increasing women's financial burden by adding transportation costs (CRR 2010).

The lack of provider training is due primarily to poor government policies that have failed to clarify who may offer safe abortion services and under what circumstances, and to ensure that enough providers are sufficiently trained in the procedure. At present, doctors are the only cadre of healthcare providers who receive explicit training in school on how to perform terminations (CRR 2010). In particular, the Ministry of Health has failed to ensure that an adequate number of providers are trained in second-trimester abortion procedures, severely limiting women's access to safe abortion after the first trimester. Due to insufficient training of healthcare providers, second-trimester abortions can be performed by only gynecologists, of which there are only 290 in the entire country (APHRC 2012).

In addition to training gaps, providers' lack of clarity on the content of the abortion law, and the circumstances under which abortion may be legally performed, has heightened the fear and stigma surrounding the procedure, deterring providers not only from offering services but from being trained to offer safe abortion services. This has further limited the number of practitioners capable of providing safe services when needed or permitted under the law (CRR 2010).

A woman able to overcome the significant financial and social obstacles to seeking post-abortion care can encounter a new set of barriers to obtaining quality post-abortion care at the healthcare facility. Delays in treatment, both deliberate and resource-based, are common. Care may be denied entirely for failure to pay a demanded bribe. When women do finally receive care, the quality of the care is often poor, characterized by verbal abuse from

healthcare staff, poorly performed MVA procedures by untrained providers lacking proficiency in MVA use and the absence of pain management. Women have few or no avenues for redress for poor treatment received while seeking post-abortion care (WHO 2008, CRR 2010). Even when a provider who is trained and willing to offer post-abortion care services is available, lack of equipment and supplies may nonetheless still delay care and impair its quality (CRR 2010).

Although the Ministry of Health has made clear that all hospitals, maternities, and health centres are expected to be able to offer 24-hour services, the 2004 KSPAS found that only 57% of hospitals, 59% of maternities, and 20% of health centres have the basic components to support such services (CRR 2010). Only 11% of all government-managed facilities have the basic components to support 24-hour emergency services. Kenyan healthcare facilities often lack basic equipment necessary for the provision of post-abortion care and safe abortion, including clean latex gloves, soap, water, disinfecting solution, sterilization equipment, and the MVA equipment itself.

MVA equipment is on the government's essential supplies list; however, survey data and interviews with healthcare providers indicate that Kenya faces a severe shortage of MVA equipment in its public healthcare system. Given that most abortions in Kenya are performed using an MVA kit and that post abortion care often requires vacuum aspiration, this presents a serious concern for the availability and timely provision of abortion services. In some public hospitals, for example, despite the presence of trained staff, MVA cannot be performed because the kits are unavailable.

A 2009 study assessed the “quality of emergency obstetric services available to women in two typical Nairobi slums, Korogocho and Viwandani (CRR 2010). Of the 25 health facilities studied within or near the two slums, only 8 facilities had MVAs available and “some of the reported equipment were not in working condition or locked up somewhere.” Only 9% of the skilled healthcare workers could perform MVA dilation and curettage (D&C) on the job (CRR 2010).

In general, the Kenyan healthcare system is not equipped to deal with the high rates of unsafe abortion cases presenting at its healthcare facilities. According to the 2004 KSPAS, only 9% of hospitals, maternities, and health centres have the capacity to provide basic emergency obstetric care (CRR 2010). When disaggregated by province, only 7% of facilities in the Rift Valley Province were capable of offering basic services, despite having by far the largest population of any province in Kenya. Only 6% of hospitals, maternities, and health centres in Kenya were found to offer comprehensive emergency obstetric services (CRR 2010).

2.5 Economic costs of safe abortion in Kenya

Safe abortion is cost saving. It is a critical factor in determining a Kenyan woman’s access to the procedure. Safe abortion services are relatively easy to access if women can afford it; but for poorer women, the costs can be prohibitive. Poverty affects women disproportionately: female-headed households in Kenya experience higher incidences of poverty than their male counterparts, in both rural and urban areas (Institute of Economic Affairs 2008). In a country where almost 40% of the population lives on less than two dollars a day and 52% of the population lives below the national poverty line, safe abortion services are out of reach for many (UNDP & HDR 2010).

For some women, cost is a complete deterrent. For others, it delays the procedure until they have raised the required amount of money, increasing the risk of complications from the termination and the potential threat posed by the pregnancy to their mental or physical health. Still for others, it forces them to seek help elsewhere and risk obtaining an unsafe abortion from an unqualified and untrained individual or herbalist who charges significantly less (CRR 2010).

The cost of safe abortion services varies widely. For instance; on one hand, in most public hospitals in Nairobi, a termination costs approximately 1,000 shillings (\$12). On the other hand, in most private hospitals in Nairobi, it charges approximately 9,000 shillings (\$105) for a termination; depending on the stage of pregnancy (CRR 2010). In most informal settlement in Kenya, the cost ranges from between 1,500–2,000 shillings (\$15–23) for a safe abortion in a clinic. However, these prices are still prohibitive for many and that a lack of money prevents women from accessing this services. In contrast, herbalists and unqualified individuals charge between 300–500 shillings (\$5–8) for their services.

The perceived blanket of illegality of the abortion procedure sometimes influences and contributes to the high cost of safe abortion services. Since abortion is illegal, some providers overcharge the patients and are extorting money from patients. Private practitioners are able to charge high fees because the number of qualified providers is limited. Costs are also inflated because only doctors are officially allowed to provide abortions, preventing other levels of healthcare providers who typically charge lower prices for their services from joining the open market (CRR 2010).

2.6 Attitudes and beliefs towards abortion

The moral worlds in which abortions take place may or may not include controversies about reproductive physiology (the beginning of life, foetal viability, foetal pain), normative sexuality, policies related to abortion (its legal status, how it should be paid for, who is the ultimate decision-maker – woman, male partner or health professional), cultural and religious norms, demographic and political trends and family dynamics. It is entirely possible that there are situations in which abortion stigma does not exist, is minimal or is less stigmatised than another condition. For instance, in Cameroon, Johnson Hanks (2002) describes a situation where local beliefs about honour, shame and motherhood make abortion less shameful than a mistimed entry into motherhood.

Zambia has one of the more liberal abortion laws in Africa, but access to safe services remains limited due to a variety of factors including policy restrictions, distance to health facilities, cost, lack of trained providers and stigma. Koster-Oyekan (1998) describes the secrecy, shame, fear of ridicule and taboos associated with abortion. She also reports a high level of unsuccessful abortions that resulted in health complications. Girls who abort are considered infectious, with the ability to harm others (Webb 2000). The potential contagion also extends to providers, hospitals, medical or nursing schools, pharmacies, family members and others.

Several qualitative studies shed light on Kenyans' varying views on abortion. A study in Nyeri County showed that older women and men were generally aware that abortion occurs in the community, yet they had profound differences in the way they viewed the procedure. Older women saw abortion in rather pragmatic terms, as a response to the socio-economic burdens of having another child or having a child too soon. In contrast, men generally viewed

abortion as a woman's strategy to conceal the consequences of premarital or extramarital sex (Izugbara 2009).

The personal beliefs of the available provider often determine access to care. The lack of clear, authoritative decision-making criteria to assist providers in determining when women qualify for a legal abortion make such arbitrary decisions difficult to challenge. Women are rendered powerless, unable to demand the right to the provision of legal medical services (CRR 2010).

Although properly performed abortion is one of "the safest" procedures in contemporary medical practice, with minimum morbidity and a negligible risk of death, there is a belief among some Kenyan women that abortion is inherently unsafe and cannot be otherwise. Some women cannot distinguish between safe and unsafe abortion, remarking that one can die when doing an abortion (CRR 2010).

2.7 Feminist perspectives related to abortion choices

Historically, men have exercised enormous power over women's bodies through controlling their sexuality and reproduction. Although most feminists endorse some right to abortion, the issue of abortion cannot easily be reduced to the interests of men versus the interests of women. Women are represented on both sides of the abortion issue, as leaders, activists and supporters. Even among feminist arguments in favour of abortion, there is a diversity of views as to the grounds that serve to justify it (Thomson 1971).

Some arguments for permitting a right to abortion depend on denying rights to the foetus. Only persons have rights and foetuses, it is argued, are not yet persons (Tooley 1972). Yet

while many arguments against abortion depend on the idea that the foetus has a right to life, not all arguments supporting legal abortion reject that right. Thomson (1971) argued that even if the foetus is a person with a right to life, there are limits on what the state can compel women who carry foetuses in their bodies to do. If women have rights over their own bodies, then they have rights not to have their bodies used by others against their will. The state has no right to force someone to donate use of her body to another person, even if that person is in extreme need. (In Thomson's famous example, a person is hooked up to a famous violinist, who will die if she withdraws her body's support. While it might be virtuous to remain hooked up, Thomson argues that it is not required by morality.) Thomson's argument stresses bodily integrity and self-ownership, and argues that if we accept these premises we can only allow foetuses to use women's bodies with women's consent. Implicit in Thomson's argument is also a point about gender equality: since we do not in general compel people (i.e., women *and* men) to donate use of their bodies to others even in cases of extreme need, then why do we think we are justified in only compelling women? (Thomson 1971).

Sherwin argues that the decision to abort should be made by the woman. This decision she and other feminists argue is best left up to the pregnant, woman for only she truly knows what is best in her situation. Sherwin states that in order to free themselves from male dominance, women must complete control over their reproductive lives. This only begins with the right to determine whether or not to abort a foetus (Sherwin 1987). She points out that women must have the freedom to choose abortions because in many cases women are unable to control their own sexuality. This she attributes to women's subordinate status (Sherwin 1987). Furthermore, if women are unable to receive abortions on demand this subordination is likely to increase because of the responsibility of caring for a child, and the increased financial need, and the decreased economic opportunities associated with child care.

Sherwin continues to argue that this dependence will imply a sexual loyalty on her part, restricting her sexuality, and further perpetuating the cycle of oppression (Sherwin 1987).

Sherwin also says that the pro-life movements have argued that women can avoid unwanted pregnancies by simply avoiding sexual intercourse. She believes that currently and historically women have little control over their sex lives, and therefore have little control over the decision to become pregnant. She adds that women are often subject to rape by strangers and those known to them. She says sexual coercion is a common practice, and often isn't even realized by the woman. The way we are socialized determines whether or not we will participate in sexual intercourse. Sexual intercourse is rarely desired, but is instead the result of force, compliance, or accommodation.

Sherwin goes even further to argue that birth control alone cannot be expected to prevent pregnancy. She argues that there is no form of birth control available that is both safe and reliable. The most effective means available, namely the birth control pill or the IUD, are known to involve health hazards for women, and therefore she cannot be expected to spend her reproductive years on these medications. As for the safer methods, being diaphragms and condoms combined with spermicidal foam or jelly is inaccurate, awkward, and expensive. This, she argues leaves only one safe and fully effective form of birth control, the use of a barrier method with the back-up option of abortion (Sherwin 1987).

The feminist perspective examines foetal development in the context in which it occurs; in women's bodies. In the feminist perspective the value of the foetus is relational rather than absolute. The feminist perspective argues that what is valued about persons is not existence, but instead personality. Therefore foetuses must not be viewed as morally significant because

they have not developed sufficiently in a social relationship. Sherwin says that because of the status of the foetus, within and dependent on a woman, the responsibility and privilege of determining its social status and value lies within the women (Sherwin 1987).

2.8 Religion and abortion in Kenya

In Kenya, religion is one of the most significant factors influencing attitudes towards abortion based on the arguments about when life begins (Gleeson *et al.* 2008). Both the Catholics and the Protestants in Kenya believe that life begins at conception. On the other hand, the Muslim scholars believe that ensoulment of the fetus doesn't occur until the 4th month of pregnancy (after 120 days). This is based on the Koran as well as narrations from the Prophet Mohammed. Jewish laws recognize the presence of a life only when the embryo is implanted (Cameron & Williamson 2003).

There has been a key debate between the Pro-life and the Pro-choice in relation to abortion in Kenya. On one hand, pro-life organizations (focusing on ethics, religion and moral value) are by all means against abortion highlighting that much effort should be around preventing unwanted pregnancies in the first place. This group has argued that abortion violates the sanctity of human life and therefore they shall not compromise on the issue. The National Council of Churches of Kenya together with the Catholic Church all fall on the pro-life group (Lee 2004)

On the other hand, pro-choice organizations (focusing on rights and health outcomes) have continuously advocated for policy changes so as to legalize safe abortions. They argue that

women must be given a right of choice in fertility issues and that religious considerations should not be used as the basis of which national laws should be implemented (Lee 2004).

2.9 Theoretical framework

This study was guided by Scheper-Hughes and Lock's (1987:3) analytical framework of 'The Mindful Body', drawn from phenomenological theory. According to Jackson (1996), phenomenology is the scientific study of experience and attempts to explain human consciousness in its lived immediacy. Scheper-Hughes and Lock were inspired by phenomenological theory in framing the Mindful body.

Scheper-Hughes and Lock (1987) conceptualised the Mindful body as constituting three bodies: individual body-self, social body, and body politic. They defined the individual body as the "phenomenological sense of the lived experience of the body-self" (Scheper-Hughes and Lock 1987:3). Through the individual body "the patient's subjective experience" of abortion is realized, analyzed and comprehended.

The social body perceives the body as a "natural symbol for thinking about relationships among nature, society and culture;" (Scheper-Hughes and Lock 1987:3). It is, regarded as a screen on which ideas of society, religion and culture are mapped. It is a body which is needed in order to live within a particular society and cultural group; it is a means whereby the physical functioning of individuals are influenced and controlled by the society that they live in. To them, "cultures are disciplines that provide codes and social scripts for the domestication of individual bodies in conformity with the needs of social and political order

and that the stability of the body politic depends on its capability to control the social bodies and to discipline the individual bodies” (Scheper-Hughes and Lock 1987:26).

The body politic is a “regulation, surveillance, and control of bodies”. It exerts a powerful control over all aspects of the individual body; its behaviour, in reproduction and sexuality, in work, in leisure and in other forms of deviance and human differences” (Scheper-Hughes and Lock 1987:4).

Relevance of the theory to this study

The mindful body is significant for it permits an understanding of the women’s body, or the “Women’s lived experience” of availing abortion or not, as reflective of tensions between the social body and the body politic. Hence, abortion is not viewed as an “isolated event” but as a means through which the women’s body is seen as the “most immediate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity and struggle.

The processes by which women interpret and rationalize their abortion experiences are diverse, evidence that the “most destructive locus of abortion stigma” is when abortion stigma permeates into the mind of individual women. Women’s internalization of abortion stigma expresses itself in feeling of guilt and shame since women feel they are defying long-held cherished ideals of motherhood and womanhood (Kumar *et al.* 2009).

The presence of strong religious and cultural anti-abortion sentiments reveals that, unless under special circumstances, the women’s right to abortion is generally not favoured. The

right of life possessed by the foetus outweighs the right of women to make decisions about their body. Moreover, the lack of access to power and resources means that women often have other individuals making decisions about their bodies.

Women in Kenya are constantly forced to contend with tensions regarding morality and abortion stigma at the community level and with their parents and partners. Even if they somehow manage to resolve these issues they must face a lack of abortion services from the State and further pressures on their decision to abort from health-care professionals. Such tensions persistently play on their minds and, for some, dealing with the matter themselves through unsafe abortion procedures is the best way to escape these barriers to safe abortion services.

Conceptual Framework explaining women's access to abortion services in Kibera informal settlements

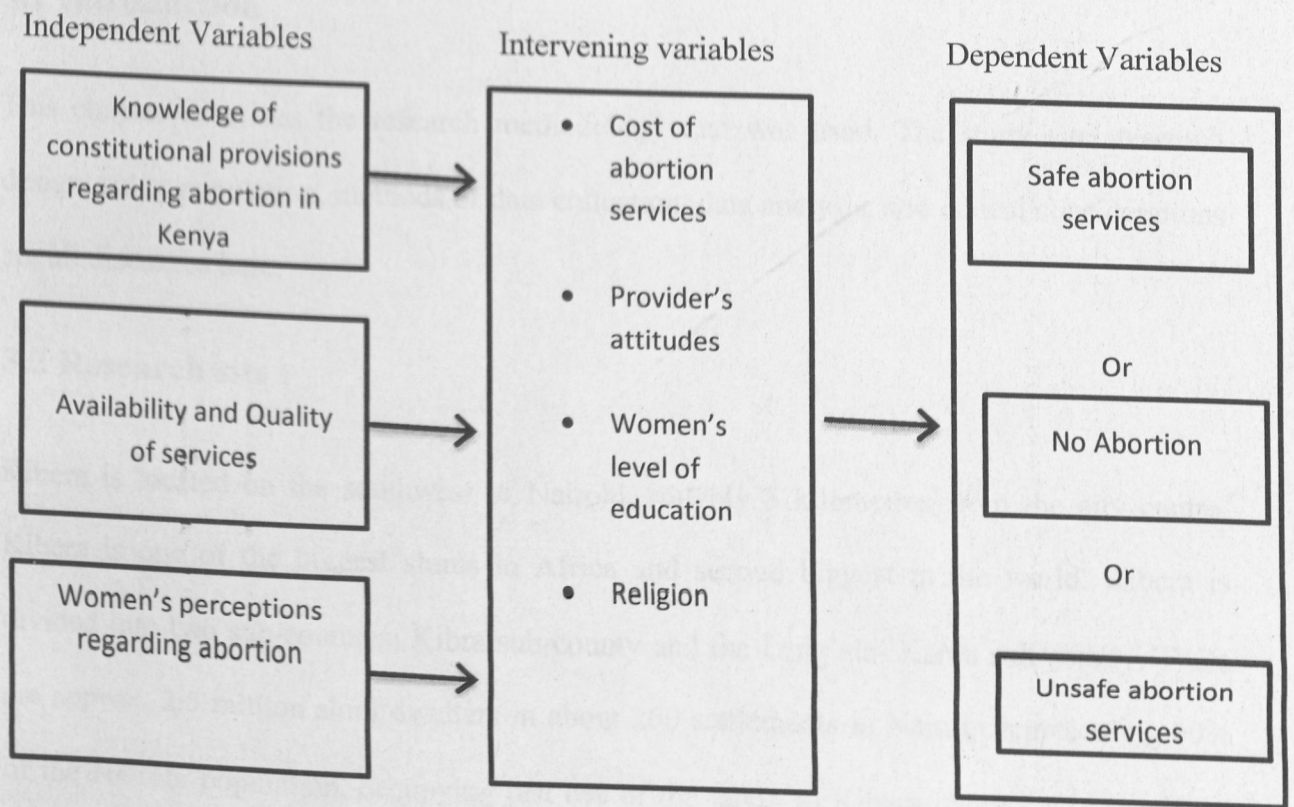


Figure 2.1 Conceptual framework

(Source: Author's study, 2014).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the research methodology that was used. The study site, research design, study population, methods of data collection, data analysis, and ethical considerations are all discussed here.

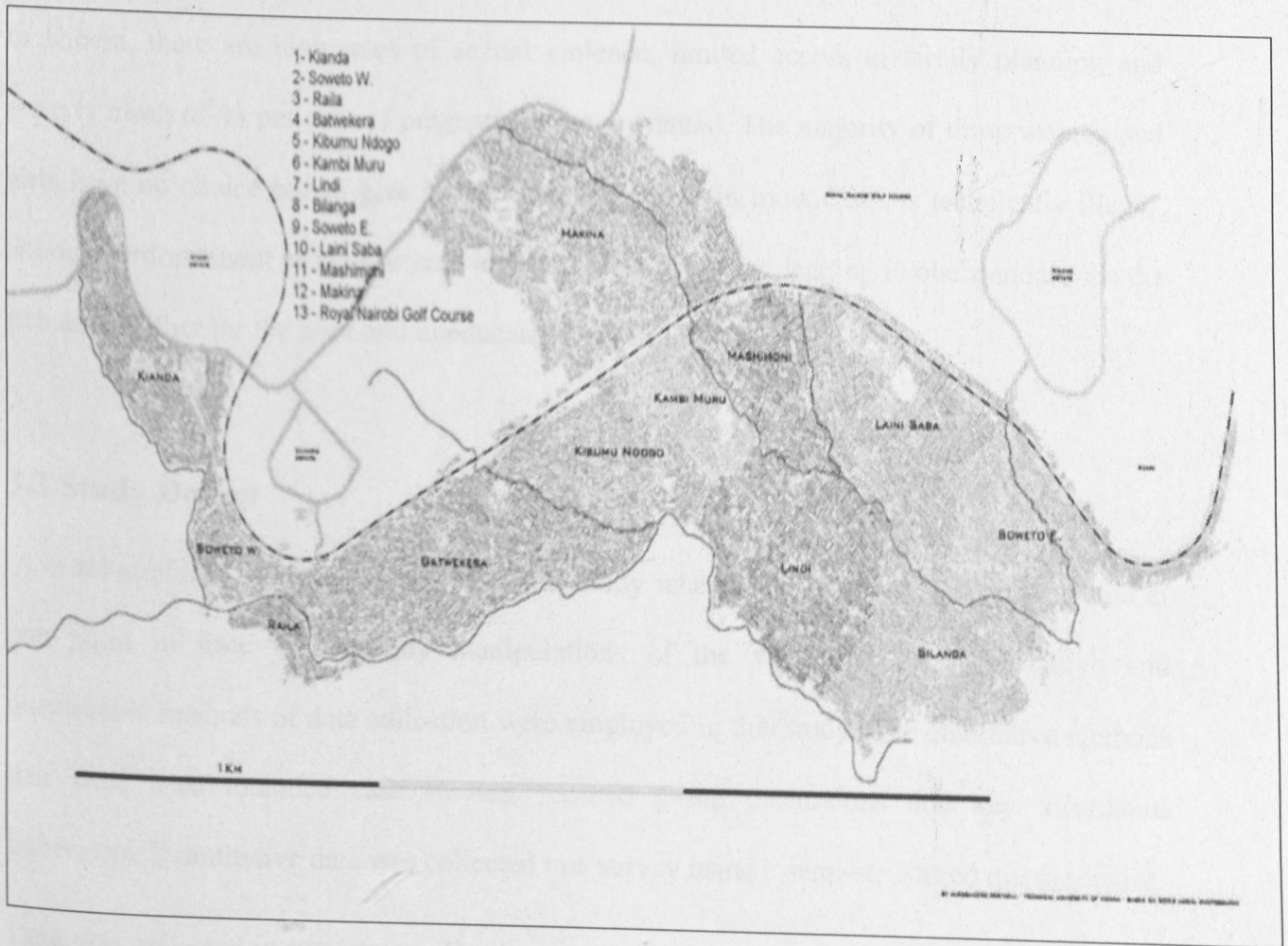
3.2 Research site

Kibera is located on the southwest of Nairobi, roughly 5 kilometres from the city centre. Kibera is one of the biggest slums in Africa and second biggest in the world. Kibera is divided into two sub-counties; Kibra sub-county and the Lang'ata- Karen sub-county. There are approx. 2.5 million slum dwellers in about 200 settlements in Nairobi representing 60% of the Nairobi population, occupying just 6% of the land. In Kibera, there are nine official villages, each with its own village elder. They are: Kianda, Soweto, Kisumu ndogo, Lindi, Laini Saba, Siranga/Undugu, Makina, Gatwekera and Mashimoni (UN-Habitat 2003).

3.2.1 Housing structures

There are more than 30,000 structures in Kibera informal settlements which are mud walled and thatched with corrugated iron sheets (Amnesty International 2009). A household in the slums comprises of seven members on average and usually stands on a 12ft by 12ft structure costing almost US\$ 15 per month. The local authorities usually issue temporary occupation licenses to the owners. Around 10% of Kibera residents own the structures and sub-let them to the remaining 90% (UN-Habitat 2003). The structures are owned by informal owners who are recognized by the tenants, but they have no legal ownership. The tenants pay a monthly micro-lease to the owners.

Figure 3.1: Map of Kibera villages



(Source: Map Kibera project 2009)

3.2.2 Health care delivery system

The Ministry of Health (MOH) in Kenya is responsible for providing health care to the Kibera population. Kenyatta National Hospital, the biggest referral hospital in East and Central Africa, is close to the Kibera informal settlements. Other health care facilities in the slum include; health clinics, dispensaries, maternity homes, nursing homes, medical centres, laboratories and radiological services, dental clinics which are owned by non-governmental organisations and private individuals.

3.2.3 Reproductive health

In Kibera, there are high rates of sexual violence, limited access to family planning and poverty mean of 43 per cent of pregnancies are unwanted. The majority of these women and girls have no choice but to give birth because abortion in most cases is technically illegal, although enforcement of laws around abortion are ambiguous, leading to one standard for the rich and another for the poor and uneducated (APHRC 2002).

3.3 Study Design

A cross-sectional design was applied in this study whereby, all variables were measured at one point in time without any manipulations of the variables. Both qualitative and quantitative methods of data collection were employed in this study. The qualitative methods that were used included case studies, focused group discussions and key informants interviews. Quantitative data was collected in a survey using a semi-structured questionnaire.

Data was collected in two stages. The first stage entailed administering of questionnaires to women of reproductive age (15-49 years) to get their understanding of the constitutional provisions of abortion in Kenya, access to safe abortion services as well as their beliefs, attitudes and practices towards abortion. The second stage entailed selection of FGD participants, key informants as well as case studies for women who had aborted, in order to get a deeper understanding of the study.

Data was analyzed by both qualitative and quantitative methods. Qualitative data was analyzed using content analysis whereby; data was read and re-read to identify the main themes that were emerging in relation to the study objectives. Narrative and verbatim quotations were used to explain the trends exhaustively. Statistical package for social sciences (SPSS) version 21 was applied to analyse quantitative data.

3.4 Study Population

A population is the total set of individuals, groups, objects, or events that the researcher is studying (Frankfort-Nachmias and Leon-Guerrero 2006). The study population comprised of women living in the Kibera informal settlements. This included women in both formal and informal employment, married and unmarried, educated and uneducated, as well as the unemployed. The population also comprised of health professionals, religious leaders and different reproductive health experts in Kibera informal settlements.

3.5 Sample population and Sampling Procedure

A sample population comprised of women of reproductive age (15-49 years) from Kibera informal settlements. A sample size of 50 women was used in this study. In Kibera there are nine official villages. The study was based in three out of the nine villages. The three villages were; Makina Village, Gatwekera village and Laini saba village, all which lies within the Kibra sub county. The three villages were purposively chosen based on their accessibility, presence of a health facility and NGOs/CBOs addressing reproductive health.

Non-probability sampling methods were used to draw the informants. Out of these three villages, a total of 50 women of reproductive age (15-49 years) were sampled using convenience method to participate in the study. The survey method was applied to the 50 women using semi- structured questionnaires. Three (3) focused group discussions comprising of 10 Participants each were conducted with a sub-sample of the women who had participated in the survey. The focus group participants were conveniently selected on the basis of who had time to participate in the discussion. Eight (8) Key informants were selected purposively and five (5) case studies were drawn using snow-ball technique.

3.6 Methods of Data Collection

The study employed mixed methods approach in data collection. This was important as it provided the benefits of different methods while compensating for some of their limitations.

3.6.1 Survey Technique

A semi-structured questionnaire (Appendix I) was administered on women of reproductive age (15-49 years) to generate their knowledge on constitutional provisions regarding abortion in Kenya, access to safe abortion services and their attitudes and beliefs towards abortion. The questionnaire was divided into two sections; section 1 entailed personal profile and section 2 entailed termination of pregnancy. A total of 50 respondents participated in the survey.

3.6.2 Focus Group Discussion

Focussed Group Discussion (FGD) is a qualitative data collection method that aims at gathering general perceptions rather than individual experiences. A total of three separate FGD's, each comprising 10 people was conducted; one for young women (Appendix IIa) and two for adult women (Appendix IIb). These FGD's were balanced in the three villages so that in each village, an FGD was conducted. The inclusion criterion was to select women who were 15-49 years of age and who had participated in the survey and had time to participate in the discussion without being compensated. This helped in gathering general views on their knowledge and understanding of the constitutional provision regarding abortion in Kenya, factors influencing access to safe abortion services in Kibera informal settlements as well as their attitudes and practices towards abortion.

3.6.3 Key informant Interviews

Key informants comprised of 2 community health workers, 3 health professionals and 3 religious leaders, addressing women's reproductive rights. The key informants were selected on the basis that they had direct or indirect engagement with women who had procured an abortion. A key informant interview guide (Appendix III) was used to collect data on the factors influencing access to safe abortion services in Kibera informal settlements.

3.6.4 Case studies

A case study guide (Appendix IV) was used to get detailed information from women who had procured an abortion. Case studies of women who had procured abortion provided concrete data on the actual experiences regarding abortion. Five cases were studied and this helped in constructing life histories of these women, to describe and clarify their experiences before and after the abortion procedure. The method explored women's lived experience with abortion, their understanding on the constitutional provisions of abortion in Kenya, factors influencing access to safe abortion services in Kibera informal settlements as well as their beliefs towards abortion.

3.6.5 Secondary data

Secondary data included information from books, journals, world health organization guidelines, newspaper reports, and theses. All these provided very rich information on abortion in different perspectives in Kenya and other parts of the world.

3.7 Data processing and analysis

Data was analyzed by both qualitative and quantitative techniques. Qualitative data was analysed by content analysis. Content analysis is a thematic analysis on the basis of a research question (Green and Thorogood: 2004). Data was synthesized and analysed in relation to the research objectives; it was presented as narrative and verbatim quotations and selected comments from informants was used to explain the trends exhaustively. Instead of relying on single data collection method, triangulation of different sources of data one with the other was used to ensure the accuracy and reliance of the information gathered. SPSS version 21 was used to analyse quantitative data. Data was entered in SPSS database where frequencies were generated and cross-tabulations were used to examine the relationships between different variables.

3.8 Limitations to the study

Studies on abortion issues are usually very personal and sensitive in nature and it was very difficult to get and select case study participants who were willing to freely share their stories. It was also a big task to convince case participants to give their opinions and experiences on abortion especially in Kenya where abortion is considered as an illegal and stigmatism act. However, with a good rapport with the women, they were able to come up and discuss issues relating to abortion freely.

Another limitation that came up was where respondents would ask for financial assistance. Many Non-governmental organizations carry out their research in Kibera and women are used to be paid or compensated for their time. This was countered by informing them clearly that this was an academic research that required voluntary participation and no one was going

to be compensated. Participants were also informed that the information that they would share would benefit them in the future.

3.9 Ethical consideration

This study obtained approval to conduct research from the National Commission of Science, Technology and Innovation (NACOSTI) and from the University of Nairobi. The researcher ensured protection of the respondent's rights; a written informed consent was obtained from each study participant. For participants aged less than 18 years, additional consent was sought from parents or guardians after respondent assent. The respondents were informed of their freedom to participate or withdraw from the study if they felt not comfortable with some questions and they were informed that they would not be penalized if wished not to participate in the study. Confidentiality was maintained by avoiding names and other personal identification information whereas privacy was maintained by conducting the interviews in a conducive and quite environment.

CHAPTER FOUR

WOMEN'S KNOWLEDGE OF THE CONSTITUTIONAL PROVISIONS REGARDING ABORTION IN KENYA

4.1 Introduction

The major purpose of the study was to explore the factors influencing access to safe abortion services in Kibera informal settlements. This chapter presents findings on socio-economic characteristic of the respondent's and women's knowledge of the constitutional provisions regarding abortion in Kenya.

4.2 Socio-economic characteristics of respondents

The socio-economic characteristics of respondents are presented in the following order; age of respondents, religious affiliation, marital status, employment status and educational status of respondents.

4.2.1 Age of Respondents

Table 4.1: Age of respondents

Age of the Respondents	Frequency	Percentage
18-28	24	48%
29-38	19	38%
39-48	7	14%
Total	50	100%

(Source: Survey data, 2014)

As indicated in Table 4.1 above, nearly half of the respondents (48%) were aged 18 - 28 years. 38% were aged 29-38 years while 14% were aged 39-48 years. All the respondents reported that they had had a sexual encounter in their lifetime and 40% (n= 20) of the respondents reported that they had had unwanted pregnancy. It was further revealed that half of the women (50%, n=10) who had unwanted pregnancies had procured unsafe abortions when they were 28 year and below.

Studies by APHRC (2011) reported that there was a decrease in the experience of unintended pregnancy (mistimed and unwanted) with an increase in age. Whereas 71.4% of the women from the slum aged 20 years and less reported having experienced unintended pregnancy, 21.2% and 18.9% aged 20 - 34 years and 35 - 49 years respectively, experienced unintended pregnancy. Other studies in Kenya have shown that severe complications of unsafe abortions were most common among women aged 10-19 (45%). About half of all PAC clients were less than 25 years of age (48%) with 17% aged 10-19 years old (APHRC 2012).

4.2.2 Religious affiliation of respondents

As indicated in table 4.2 below, almost half of the respondents were Muslims. They were mainly women from the Nubian community in Kibera. 30% of the respondents were Christian-Roman catholic, 20% were Christian- protestant while only 4% encompassed respondents from other religions.

Table 4.2: Religious affiliation of respondents

Religious affiliation	Frequency	Percentage
Christian-Protestant	10	20%
Christian-Roman Catholic	15	30%
Muslim	23	46%
Others	2	4%
Total	50	100%

(Source: Survey data, 2014)

This study revealed that all religions were against abortion, they considered it as murder. However, half of the respondents (50%, n=5) who had procured an abortion were Muslims. It was reported that one of the striking reason that came up as to why women and girls procured abortions was due to pregnancy that resulted from two different and competing religions, (Islam and Christians). A 35 year old Nubian and a widow explained that:

“When a woman especially a Muslim woman knows that she has been impregnated by a Christian man, she will always procure an abortion. She will do this in a very secretive manner, that is, through back street providers, so that her fellow Muslims would not know what happened. There is a lot of stigma attached to a woman who is impregnated by a Christian; in Islam, this woman will be considered as an outcast and she may feel odd when attending the mosque”.

4.2.3 Marital status of respondents

Table 4.3 below shows that three quarter of the respondents were single at the time of the study, most (49%) of the singles were from the ages 29-38 years. It was reported that most single women had 1-2 children to take care of. They took care of their children by themselves while few others got assistance (especially of school fees, clothing and medical care) from

NGO's and other charitable institutions in Kibera. 20% of the respondents were married and most of them were within the age bracket of 18-28 years. Only 10% were divorced/separated and they were aged 39-48 years.

Table 4.3: Age (Binned) * Marital status cross tabulation

Age Group		Marital status			
		Divorced/widowed	Married	Single	Total
18-28	N	0	8	16	24
	% within Marital	0%	80%	46%	48%
	% of Total	0%	16%	32%	48%
29-38	N	1	1	17	19
	% within Marital	20%	10%	49%	38%
	% of Total	2%	2%	34%	38%
39-48	N	4	1	2	7
	% within Marital	80%	10%	6%	14%
	% of Total	8%	2%	4%	14%
Total	N	5	10	35	50
	% within Marital	100%	100%	100%	100%
	% of Total	10%	20%	70%	100%

(Source: Survey data, 2014)

This study revealed that high rates of unintended pregnancy occurred amongst the single and divorced/widowed women. About a quarter of the single women and almost half of the divorced/widowed women had experienced unintended pregnancies as compared to married women. Most of the unintended pregnancies were reported to have been aborted. This concurs with a study that was carried out by the APHRC (2012) which indicated that never married women experienced the highest prevalence of unintended pregnancy compared to currently married women from slum and non-slum settlements. Fifty-five percent of never married slum women experienced unintended pregnancy compared to 12.8% of those

currently in a marriage. Over 66% of never married non-slum women experienced unintended pregnancy compared to 13.8% currently in a marriage.

4.2.4 Employment status of respondents

Table 4.4: Age (Binned) * Employment status cross tabulation

			Employment			Total
			Formal	Informal	Unemployed	
Age (Binned)	18-28	Count	3	4	17	24
		% within Employment	50%	29%	57%	48%
		% of Total	6%	8%	34%	48%
	29-38	Count	3	4	12	19
		% within Employment	50%	29%	40%	38%
		% of Total	6%	8%	24%	38%
	39-48	Count	0	6	1	7
		% within Employment	0%	43%	3%	14%
		% of Total	0%	12%	2%	14%
Total	Count	6	14	30	50	
	% within Employment	100%	100%	100%	100%	
	% of Total	12%	28%	60%	100%	

(Source: Survey data, 2014)

As indicated in table 4.4 above; of the respondents, 60% (n=30) were unemployed, almost half of them (34%, N= 17) were in the age bracket of 18-28 years. 28% of the respondents were in informal employment whereby majority of them were aged 39-48 years. Only 12% of the respondents were in the formal employment. With the high unemployment rate of the respondents, it was revealed that most women who experienced unintended pregnancies could not afford safe abortion services and the only option available for them was to seek

unsafe abortion services from unqualified providers. Other studies have indicated that women in formal employment were 0.5 times less likely to experience unintended pregnancy compared to unemployed women or students. Self-employed women were 0.7 times less likely to experience unintended pregnancy compared to unemployed women or students (APHRC 2011).

Studies by (APHRC 2002) have indicated that poor women have little or no source of income and they account for most cases of unsafe abortions in public hospitals. This group is also disadvantaged largely due to lack of access to reproductive health services. Findings from this study showed that, the unemployment rate is very high at 60% (n=30) as shown in table 4.4 above. Most of the unemployed respondents admitted obtaining an income through informal businesses like washing clothes and house hold chores in the nearby middle class estates; which was not paying much money. Others did hawking and selling vegetables while others admitted that they got their money from boyfriends/male friends. Very few got assistance from their parents/Guardians. Majority (70%, n=35) of the respondents admitted that they earned at most Ksh. 200 a day for doing such kind of jobs.

4.2.5 Education status of respondents

Education is fundamental for both labour market achievement and the fight against poverty. As indicated in table 4.5 below, 70% of the respondents were primary school drop outs. They formed part of the larger percentage of the unemployed. They were also the majority of those who worked in informal jobs. Most of the respondents admitted that lack of money to pay for their school fees was a major reason why most girls dropped out of school at primary level. 20% of the respondents were educated up to secondary level while only 10 % went up to

college level and they formed the larger percentage of those who worked in the formal employment.

Table 4.5: Education status * Employment status cross tabulation

Education Status		Employment status			Total
		Formal	Informal	Unemployed	
Primary	N	0	11	24	35
	% of Total	0%	22%	48%	70%
Secondary	N	2	3	5	10
	% of Total	4%	6%	10%	20%
College	N	4	0	1	5
	% of Total	8%	0%	2%	10%
Total	N	6	14	30	50
	% of Total	12%	28%	60%	100%

(Source: Survey data, 2014)

Studies by (APHRC, 2012; CRR 2010) indicate that the issues of unwanted pregnancies and unsafe abortions are very much related to poverty. This is more in rural areas and in the urban slums. With poverty, it means that most women/girls are not well educated and hence they end up being the majority of the unemployed. This is in relation to the study findings where majority of the respondents were primary school drop outs and were unemployed at the time of the study.

4.3 Women's knowledge of constitutional provisions regarding abortion in Kenya

One of the specific objectives of the study was to establish the women's understanding of the provisions regarding abortion in the 2010 Kenyan constitution. In 2010, Kenya adopted a new constitution that provides stronger protection for the lives and health of women (NCLR 2010). Whereas the prior law only allowed abortion to protect the pregnant woman's life, Article 26 (4) of the new constitution explicitly permits abortion when "in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the [pregnant woman] is in danger, or if permitted by any other written law." (NCLR 2010, CRR 2010) The constitution also states that "a person shall not be denied emergency treatment." (NCLR 2010)

The findings as indicated in table 4.6 below revealed that only 20% of the respondents were aware of what the constitution provided for abortion in Kenya. Most of them were educated up to secondary and college levels. This suggests that 80% of women in Kibera informal settlements lacked information of their abortion right. Majority of them (94%) were primary school drop outs. Therefore, their sexuality and reproduction rights were being influenced by the laws and regulations that denied them their abortion rights. In this regard, women were forced to seek abortion services through informal means. Since abortion services were perceived to be illegal, the only option available was to seek unsafe abortion services.

During FGD sessions, it was observed that most of the participants did not know anything about the constitutional provisions regarding abortion in Kenya. Those who knew what the constitution said about abortion only cited one provision; "when the mother's health or that of

the child is in danger". Women participants had a heated discussion on the issue of legalization and accessibility of safe abortion services. Most of them believed that women's abortion is becoming common in Kibera and hence, creating access to safe abortion services would protect the women's life while a few of the participants felt that facilitating access to safe abortion services may encourage promiscuity.

Table 4.6: Education * knowledge of Constitutional provisions of abortion cross tabs.

			Knowledge of constitutional provisions of abortion in Kenya		Total
			Yes	No	
Education	Primary	Count	2	33	35
		% within Education	6%	94%	100%
		% of Total	4%	66%	70%
	Secondary	Count	4	6	10
		% within Education	40%	60%	100%
		% of Total	8%	12%	20%
	College	Count	4	1	5
		% within Education	80%	20%	100%
		% of Total	8%	2%	10%
Total	Count	10	40	50	
	% within Education	20%	80%	100%	
	% of Total	20%	80%	100%	

(Source: Survey data, 2014).

During an FGD session, a 35 year old woman from Laini saba village explained that:

"I totally have no clue of what the constitution talks about in relation to abortion. What I know for sure is that abortion is "Haram"- illegal in Kenya. When you talk of safe abortion services, I get confused even more. All I know is that abortion is a crime. Even our Islam religion does not allow it".

Another participant, a 25 year old single woman from Laini Saba village added that:

“If the government could have legalized abortion, we could have heard in the media about it. We have never seen even our human rights activists demonstrate on issues of unsafe abortion which are rampant in Kibera. That means abortion is still illegal”.

This fact signifies that no sufficient awareness raising activities have been made to familiarize the new law so far and hence women are still looking for illegal services which expose them to health risks.

The health care professionals admitted that the constitution has not made any changes in relation to abortion in Kenya. A medical doctor at Kibera Health Centre explained that:

“Despite having cited very well in the constitution on who qualifies to get abortion services, magnitudes of women are still procuring unsafe abortions. This means that they either don’t understand what the constitution talks about or to them, it does not matter. Consequently, the cases of post abortion care are on the rise. Since women know that they can’t be sent back, they initiate an abortion process and rushes to the hospital where a complete abortion must be done. I think there should be advocacy and creating awareness especially on the risks involved with unsafe abortion practices”.

This study concurs with a survey that was carried out on Kenyan adolescents which found that many young people in Kenya are under the false impression that the law prohibits abortion entirely (Mitchelle *et al.* 2006). Similarly, a 2003 study of 614 secondary students in Kenya found that almost a third of students (29%) believed, incorrectly, that abortion was never permitted in Kenya, and another 14% reported that they did not know whether it was ever legal or not, this extends to adults as well (Mitchell *et al.* 2006). It’s clear that women’s perceptions did not change with the promulgation of the new constitution in 2010.

Research by Centre for Reproductive Rights in 2010 indicates that Women are reluctant to seek help from qualified healthcare providers or counsellors because of the shame and fear of legal ramifications associated with abortion. As a woman in a focus group discussion in Mombasa explained, *“The problem is that abortion is not legal in Kenya and there is a lot of stigma surrounding abortion. You don’t want to seek help publicly. You go to a private, unqualified hospital”* (CRR 2010).

Interviews with the health professionals in Kibera informal settlements indicate that most health providers are aware of what the constitution says about abortion but due to their individual beliefs and moral principles, they do not support abortion. The health professionals admitted that the constitution has done nothing to curb the incidence of unwanted pregnancies and unsafe abortions in Kenya.

Evidence from the KNCHR report (2012) demonstrates that the Kenyan government has failed to address the well-known barriers that perpetuate high maternal mortality from unsafe abortion. Key among these factors are socio-cultural barriers, low levels of awareness by women of the laws providing access to safe abortion, religious perceptions, and stigma perpetuated by both the community at large and health care providers. The KNCHR report also identified particular categories of professionals who have the potential to be barriers, and who need enhanced capacity building in order to promote access to safe abortion services. Many medical providers and police officers for instance, are unsure of whether abortion is legal or illegal in Kenya. As a result, various health facilities avoid administering the procedure, even when a woman qualifies under the provisions of the Constitution, for fear of being prosecuted and imprisoned (KNHCR 2012).

This chapter presented on the women's knowledge of the constitutional provisions regarding abortion in Kenya. Based on the study findings, it is evident that most women in Kibera are not aware of what the constitution provides for abortions in Kenya. Awareness and access are the two foremost areas where improvement in comprehensive abortion services is necessary and possible. The situation in Kibera clearly shows that law without advocacy and awareness creation is by itself nothing. The effective implementation of the constitution in Kenya has the potential to promote women's access to safe abortion services and support reductions in complications of unsafe abortion. An urgent need also exists for the training of providers to offer safe abortion services and for the wider implementation of the abortion care-related Standards and Guidelines of the Ministry of Health. The next chapter will be looking at the availability and accessibility of safe abortion services in Kibera informal settlements.

CHAPTER FIVE

AVAILABILITY AND ACCESSIBILITY OF SAFE ABORTION SERVICES IN KIBERA INFORMAL SETTLEMENTS

5.1 Introduction

The study examined the availability and accessibility of safe abortion services in Kibera informal settlements. The findings are presented along the following themes; availability and accessibility of safe abortion services, cost of safe abortion services, women's understanding of what safe abortion services entails and women's knowledge of medical abortion. The chapter also presents the quality of services at the hospitals/clinics in Kibera that offer safe abortion services as reported by respondents and as observed by the researcher.

5.2 Availability and accessibility of safe abortion services in Kibera

Availability and accessibility of safe abortion services in Kibera informal settlements was one of the specific objectives of this study. Findings of the study revealed that most respondents admitted that there were no hospitals or clinics where someone could procure safe abortion in Kibera. Of the respondents, 50% had not heard of safe abortion services and did not know where those facilities were located. About 40% (n=20) of the respondents had heard that someone could procure abortion safely in some hospitals and clinics in Kibera but did not know where those facilities were located. Only 20% (n=10) of the respondents admitted that they knew the facilities that offered safe abortion services and they also knew where they were located. Some of those who knew these places were either referred there by a CHW for a post abortion care or for abortion services. They named about 3 major facilities and several

other clinics that offered abortion services within Kibera. However, medical experts in Kibera reported that some of the clinics that offered abortions were not approved by the Ministry of health to perform abortions. One medical doctor said that:

“Those clinics are the ones that perform unsafe abortions to women in Kibera. They do the abortion process in a very risky manner and women end up having post abortion complications. Some medical doctors have also turned their houses to be abortion clinics. The only hospital that is approved to perform abortions in Kibera is Marie Stopes”.

Most of the respondents (50%, n= 25) admitted that they were not aware and did not know of any facilities that offered safe abortion services. The few who had heard about such facilities believed that women bribed doctors with huge amount of money for them to receive good services. Very few respondents (10%) though, admitted that they were aware of the safe abortion services and they knew where they were located. One respondent in the case study, a 24 year old woman from Gatwekera village said that:

“Marie Stopes is just a walking distance from my work place. When I wanted to perform an abortion, I was referred there by a friend and I visited the place. I made an appointment the following day and in thirty minutes time, I was done with the procedure. It was very safe and I went back to work”.

During data collection, I visited Marie Stopes Centre in Kibera informal settlements. The hospital was clean, well equipped and had friendly providers. I talked to one doctor who mentioned that the hospital dealt with reproductive health issues such as family planning, post abortion care, safe abortion services, HIV & STI testing and management, Prevention of Mother to Child (PMTCT) for HIV, counselling among many other services. I had an in depth

interview with the doctor and he said that; at Marie Stopes, safe abortion services were performed so well and up to standard with no major complications. He explained that they performed both medical and surgical abortions. With medical abortion, Mifepristone and Misoprostol drugs were used. He further added that the procedure was done for pregnancies whose gestational age was up to 9 weeks (63 days). Manual Vacuum Aspiration (MVA) technique was used for surgical abortion for pregnancies of up to 12 to 14 weeks while for pregnancies over 12 to 14 weeks, Dilation and Evacuation (D&E) plus medical methods (mifepristone and misoprostol drugs) were used.

This study revealed that 50% of women in Kibera informal settlements were not aware of the availability or location of facilities that offered safe abortion services; hence, they sought abortion services from unqualified providers in Kibera. This suggests that abortion is viewed with a lot of stigma and negativity in Kibera. It was also observed that most women, even those who had procured abortions from safe providers, could not discuss freely on issues relating to abortion with the other women who had not procured abortions. This scenario inhibited the spread of information regarding safe abortion services in Kibera.

5.3 Cost of safe abortion services in Kibera

This study investigated on the cost of safe abortion services in Kibera informal settlements. Of the respondents, 70% said that the cost in Kibera ranged from Ksh. 6,000 to Ksh. 7,000 as indicated in Figure. 5.3 below. This was said to be the major reason why most women could not even bother to know where the facilities for safe abortion services were located. The price was said to be too high for most women, especially those who were unemployed and this meant that unsafe abortion from unqualified persons was the order of the day. About 20%

(n=10) of the respondents said that the price ranged from Ksh. 8,000 to Ksh.10,000 while only 10% (n=5) of the respondents said that the price ranged from Ksh. 3,000 to Ksh.5,000.

One of the Key informants from Marie Stopes Centre mentioned that they charged a minimum cost of Ksh. 7,000 for safe abortion services. He reported that when a girl or woman went to the hospital for abortion, they had to be examined first by being tested for pregnancy to ascertain their gestational age, after that, they are tested for any STI or HIV. They are also screened for cervical cancer. Safe abortion is then performed and women are cleaned so well that someone could go and continue with their daily activities. In addition, he also pointed out that if a woman was found to have any STI's, she is treated for that infection. It was also reported that women were given post abortion counselling and contraceptives to ensure that they did not go back with unwanted pregnancies or STI's. He summed up by saying that all these services accounted for the high cost of safe abortions at Marie stopes.

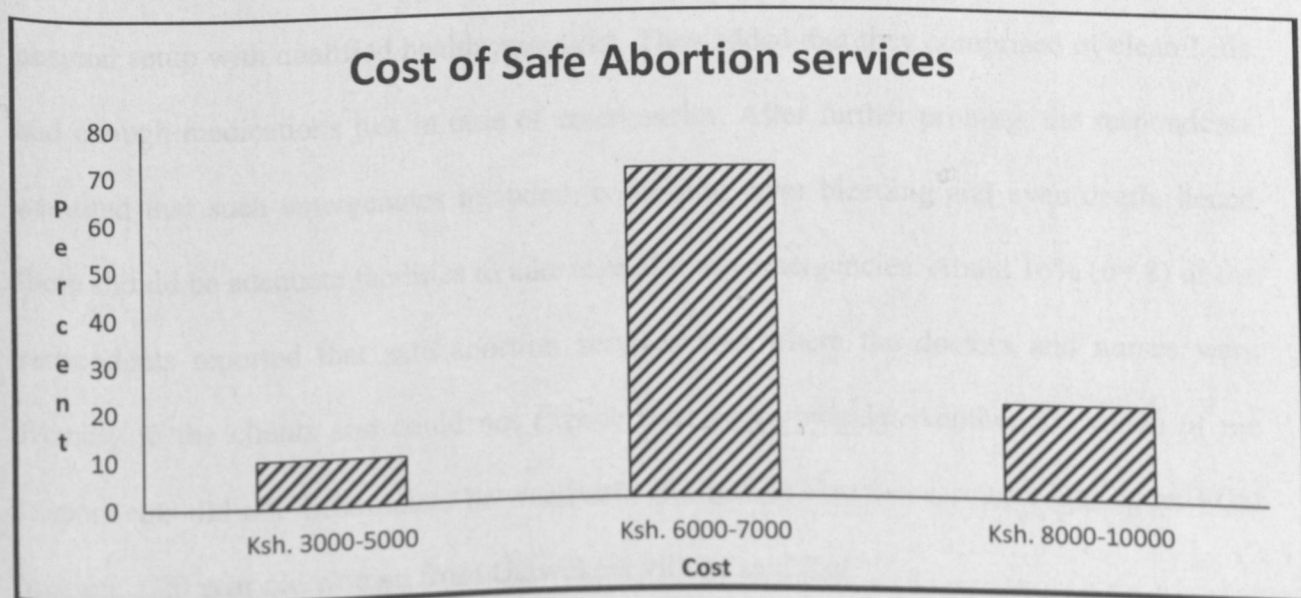
During focussed group discussions, it was said that unsafe abortion from unqualified providers was affordable to women in Kibera slums. Most of the respondents admitted that it costs about Ksh.500 to Ksh. 1,000 to procure abortion from unqualified providers. It was mentioned that the commonly used methods by unsafe providers included herbal concoctions, insertion of sharp objects such as straw, hanger or sharp wires in the woman's womb so as to pierce the uterus and hence induce an abortion. Other abortifacient included concentrated quencher, jik, tea leaves, coke, among others but were not so common these days as they were before. Due to its affordability, most women sought abortion from unsafe providers. A key informant from Makina village narrated that:

"A good thing with the unsafe providers is that their prices are manageable and they are easily available. They sell their concoctions in the open market. The only unfortunate thing is that sometimes when the pregnancy is past 6 months, chances of deaths and complications are very high; but these providers will never warn a client.

In fact, we have one old abortionist woman in this village who risks women's life every day. In a month, there must be a death case from his black market in abortion. The most surprising thing is that, whenever this old woman is arrested, she makes her way out of the police custody through bribery means. Her abortion cost charges around Ksh.200 to500".

Whether safe or unsafe abortion services, most respondents reported that what mattered was the age of the pregnancy. Young pregnancies (1-3 months old) were much cheaper as compared to older pregnancies (4-7 months old). While conducting FGD with young women, most of the discussants who had been to Marie Stopes reported that abortions at Marie Stopes could be done up to 7th month of pregnancies. They said that the cost of safe abortion at Marie stopes was majorly determined by the gestational period of the pregnancy. They reported that pregnancies that were 2 months old cost Ksh. 4000, 3 months old cost 5000, 5 months old cost Ksh. 7000 while pregnancies that were above 6.5 months could cost up to Ksh. 20,000.

Figure 5.1: Cost of safe abortion services in Kibera (n=50)



(Source: Survey data, 2014)

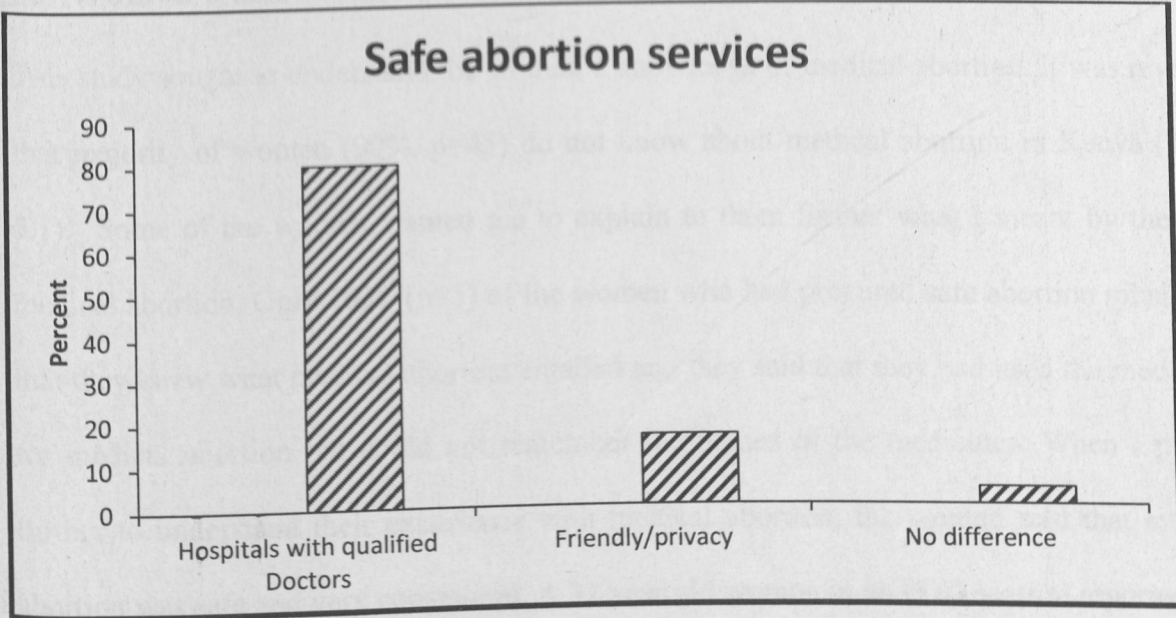
Anecdotal evidence from providers suggests that the cost of clandestine abortion varies widely. Private and public providers may charge anywhere from 1,000 to 10,000 Kenyan shillings (US\$12–122), depending on gestation and sometimes on what the woman can afford (CRR 2010). In one study, women reported paying between 150 and 12,000 Kenyan shillings (US\$2–146) to terminate their pregnancy (KHRC 2010). This study revealed that the cost of safe abortion services in Kibera was too high that most women could not afford. Even those who knew the place where safe abortion could be offered were hindered to access the facility due to the high costs. It is therefore important to note that even if safe abortion services are made available and accessible for the women, the cost should be affordable as well especially for the poor women in the Kenyan slums and rural areas.

5.4 Women's understanding of safe abortion services

The study sought to investigate the women's understanding of safe abortion services. Almost three quarter of the respondents said that safe abortion service was the one that involved a hospital setup with qualified health personnel. They added that they comprised of clean beds and enough medications just in case of emergencies. After further probing, the respondents admitted that such emergencies included; collapsing, over bleeding and even death, hence there should be adequate facilities to take care of those emergencies. About 16% (n= 8) of the respondents reported that safe abortion services was where the doctors and nurses were friendly to the clients and could not expose their cases outside. Another 4% (n=2) of the respondents did not differentiate between safe and unsafe abortion services. During an FGD session, a 20 year old woman from Gatwekera village said that:

“There is nothing to call safe here. It is just a probability for one to be alive or dead after abortion. Even with medical doctors, someone can die on their hands. To me, abortion is bad and anyone who wants to abort should be ready to die or live”.

Figure 5.2: Respondents’ understanding of safe abortion services (n=50)



(Source: Survey data, 2014)

Abortion safety includes not only the physical safety of women, as promoted by access to competent operators and appropriate facilities (WHO, 2011), but must also protect the psychological safety of women undergoing the procedure, as promoted by respectful and humane abortion care attitudes and practices of professional caregivers (Huntington, 2002; Slade, Heke, Fletcher, & Stewart, 2001).

Psychological safety in abortion care is less dependent on what technical care is delivered than on “the way (emphasis added) care should be delivered” (Slade et al., 2001: 72) and “the quality (emphasis added) of care received from staff” (Slade et al., 2001: 72). Thus, although their physical safety may be protected, women who access technically appropriate abortion services but receive them in dehumanizing or demeaning ways do not access safe abortion

services as their psychological safety remains at risk. Safe abortion care refers to both physically and psychologically appropriate abortion services.

5.5 Women's knowledge of medical abortion

This study sought to understand the women's knowledge of medical abortion. It was revealed that majority of women (90%, n=45) do not know about medical abortion in Kenya (Table 5.1). Some of the women wanted me to explain to them further what I meant by the term medical abortion. Only 10% (n=5) of the women who had procured safe abortion mentioned that they knew what medical abortion entailed and they said that they had used the medicines for medical abortion but could not remember the names of the medicines. When I probed further to understand their experience with medical abortion, the women said that medical abortion was safe and very convenient. A 32 year old woman in an FGD session reported:

“When I wanted to procure an abortion, I made enquiries on the place where I could procure safe abortion in Kibera. When I talked to one of my workmate and a close friend, she directed me to Marie Stopes in Kibera. I was 6 weeks pregnant when I went to Marie stopes. The doctor examine me, he tested me for various diseases including cervical cancer and HIV; and he gave me a pill which I took and told me to go back to the hospital after 1 day. When I went back, I was given another pill and within 3 days, the abortion had taken place safely without any complications. I only paid Ksh. 6000 for the whole procedure. Thanks to Marie Stopes”.

During FGDs, participants said that they did not know what medical abortion was. They also said that they had not heard of it or known where such abortion methods were found. Most of them believed that safe abortion entailed surgical procedures. I visited a number of pharmacies in Kibera and when I enquired whether they were selling Mifepristone or Misoprostol, none of the pharmacists confirmed that they were selling such drugs. One of the

pharmacists in Laini Saba village said that “those drugs are found in government hospitals and in their pharmacy. Us we are not allowed to sell those drugs”.

Table 5.1: Women’s knowledge of Medical abortion (n=50)

Knowledge of Medical abortion	Frequency	Percentage
Yes I Know	5	10%
Don’t Know	45	90%
Total	50	100%

(Source: Survey data, 2014)

The World health organization (WHO) in 2012 published “Safe abortion: technical and policy guidance for health systems” as the first global guidance for abortion related care and policy issues; including prevention of unwanted pregnancy, prevention of unsafe abortion, post abortion care, monitoring and evaluation, advocacy and others. It also spelt out the guidelines for both medical and surgical methods of safe abortions. However, during facility assessment, it was found that only Marie Stopes Centre was conversant with these policies and guidelines. Other private clinics still used the dilatation and curettage (D&C) methods of abortion. In addition, some clinics also created an impression of performing safe abortions to their clients but in real sense, they were performing unsafe abortions since they lacked the necessary equipment and trained personnel to offer safe abortion.

Kibera Health Centre (MOH) did not perform any form of abortion. The health providers said that they referred both abortion and post abortion cases to either Kenyatta National Hospital (KNH) or Marie Stopes Centre in Kibera; because they lacked the necessary equipment’s for

performing abortions. Studies by have shown that although the Ministry of Health has made clear that all hospitals, maternities, and health centres are expected to be able to offer 24-hour services, the 2004 KSPAS found that only 57% of hospitals, 59% of maternities, and 20% of health centres have the basic components to support such services (CRR 2010). Only 11% of all government-managed facilities have the basic components to support 24-hour emergency services. Kenyan healthcare facilities often lack basic equipment necessary for the provision of post-abortion care and safe abortion, including clean latex gloves, soap, water, disinfecting solution, sterilization equipment, and the MVA equipment itself (CRR 2010).

It is therefore evident that medical abortion methods are not known by majority of women in Kibera informal settlements. Accordingly, most women (90%) still believe that safe abortions are only done through surgical procedures. The study found that medical abortion was only practiced in private hospitals within Kibera such as Marie Stopes hospital. Even though doctors at Kibera Health Centre were aware of the guidelines from the ministry of health, they didn't perform abortions due to lack of necessary equipment to facilitate the services.

5.6 Quality of services at facilities that offer safe abortion services in Kibera

The study examined the quality of services at facilities that offer safe abortion services in Kibera. Findings show that almost 70% (n= 7) of the women who had been attended at the hospital or clinics in Kibera where safe abortion services were offered admitted that the doctors and nurses there were very good, organized and helpful. They did not ask offending questions and they respected and listened to the respondents quite well. A key informant from one of the programs offering reproductive services in Kibera pointed out that:

“Most mentors and social workers in those health facilities are victims of abortion. They therefore treat other women with respect because they know what the abortion experience entails”.

About 10% of the respondents reported that, since they had initiated an abortion from home and went to hospital when their situation worsened, the providers were very angry with them and instead of helping them; they started questioning them first before addressing their problem. Conversely, they admitted that the services were good. Only 5% of the respondents admitted that some providers talked about their privacy with the CHW's who at the end of the day took the information to the people in the villages. The remaining percentage said the treatment from providers was average.

Despite all this, after the abortion process, very few (30%, n=3) of the respondents reported that they received a post abortion counselling and contraceptives. This clearly indicates that, even if women were given safe abortion services, without post abortion counselling, they may end up coming back again with unwanted pregnancies or an already induced abortion.

This chapter sought to investigate the availability and accessibility of safe abortion services in Kibera informal settlements. It was revealed that availability of safe abortion services was determined by the location and cost of the abortion services. Almost half of the respondents did not know the location of facilities that offered safe abortion services. In addition, the cost of safe abortion services was also mentioned to be an important factor that influenced women's access to safe abortion services. More than half of the women in this study reported that safe abortion services cost about Ksh. 6000-7000, which was said to be expensive especially for women in Kibera informal settlements who are living on less than 2\$ a day. As shown in table 5.1, about 90% (n=45) of the respondents did not have a clue on medical

abortion (Mifepristone and misoprostol). They assumed that safe abortion only entailed surgical abortion.

Figure 5.3: Respondent's perception on quality of services at facilities that offer safe abortion services in Kibera (n=10)



(Source: Survey data, 2014)

It is evident that for women to access safe abortion services in Kibera informal settlements, they must know the location of facilities that offer safe abortion services and the cost of safe abortion services must be affordable. There is need for awareness creation and dissemination of information to women in Kibera on the medical methods of abortion so that they can make sound decisions regarding their reproductive rights. The next chapter will present on how women's attitudes towards abortion influenced their access to available abortion services in Kibera informal settlements.

CHAPTER SIX

WOMEN'S ATTITUDES AND PRACTICES TOWARDS ABORTION IN KIBERA INFORMAL SETTLEMENTS

6.1 Introduction

This study assessed how women's attitudes towards abortion influenced their access to available abortion services in Kibera informal settlements. The findings are presented along the following themes: women's attitudes towards abortion services and the influence of religion on abortion in Kenya.

6.2 Women's attitudes and practices towards abortion in Kibera informal settlements

Women's attitudes towards abortion and their influence on access to available abortion services in Kibera was one of the specific objectives of this study. Majority (60%, n=30) of the respondents were against abortion as a practice. Even those who had procured abortions reported that they could not advise someone to undertake the procedure. They viewed abortion as a sin and illegal basing from both religious and legal perspectives. It was observed that this kind of attitude drove women to procure unsafe abortions from unqualified providers so as not to be identified by their families, friends or even the law.

Case 1: In this study, a story of a 22 year old girl who participated in a Case narrative explained the way she was forced to procure unsafe abortions so as to avoid the stigma from friends and relatives. She narrated that:

"I started feeling unwell for a period of about two weeks. Nothing hit my mind that I could be pregnant. After the second week, I barely ate anything. I decided to buy a pregnant test kit from a nearby pharmacy in Kibera; unfortunately, I found that I was indeed pregnant. The first thing I did was to inform my boyfriend. He took off and asked me never to call him again. Life started taking a different shape in me. I was staying with my sister and she was the sole breadwinner of her family of 2 children. I stayed for two months trying to figure out what I could do but I did not have any idea. I was a very active member at our youth service in the church by then. I felt like friends and relatives would be disappointed with me when they found out that I was pregnant. On the third month, I decided to talk about the pregnancy issue with my sister. All she could do was to ask me to get any kind of job as soon as possible, so that I could raise money for abortion before people knew that I was pregnant. I got a job of washing clothes in a nearby estate and started saving about 150/= per day. After a couple of weeks, I had accumulated about 2000/=. I asked a friend where I could procure an abortion and she willingly took me to a private clinic in Kibera. The provider was willing to attend to me because I had some money. The environment was so scary, there was only one bed and a doctor's seat and table. A small shelf with very few containers of drugs could be seen on one corner of the room. The doctor explained that if I made any noise, people will come in and both of us would be in trouble. He inserted a huge syringe with a sharp point through my vagina and I started feeling a lot of pain. The pain became unbearable and at the moment, I was bleeding heavily. He gave me very heavy cotton to put in between my legs and some panadol as painkillers. I left for home after about 30 minutes, I barely slept that night. My sister attended to me and she reached a point that she was so scared. I was still bleeding heavily. The following day, I could not even walk. My sister rushed out and called a neighbour, she explained the situation and immediately the neighbour called one of the CHWs in our village. When she arrived, she referred me to Marie Stopes in Kibera. At the hospital, I was attended to by the doctors very fast. They cleaned me up and removed all the remains that were left in my uterus. I spent one night in the hospital and was released the following day after paying a fee. The experience was so painful, I would never advise anyone to perform abortion from unsafe providers".

Case 2: A 17 year old young woman from Makina village, a primary school drop-out narrates how family's poor state influenced her to sleep around with men and when she became pregnant, she decided to procure unsafe abortions to avoid being arrested by the police.

"I left school at age 14 to support my family. My father died when I was very young and my mother, who is HIV positive, has been providing for us as well as educating us until she developed AIDS related complications that she can no longer work. I picked up from there and started doing house hold chores in people's houses such as washing clothes, cooking and other domestic chores where I could be paid Ksh. 200 a day. This sustained us for a while until the jobs started becoming scarce as there were many women looking for such kinds of jobs. I started going for days without getting any job and this compromised food provisions in my family. Some friends advised me to start engaging into sex business which was said to be very lucrative. I did not hesitate, I started sleeping with men for money and I could earn about Ksh. 100-150 in a day. Sometimes, men could have sex with me and refused to pay me but this was not so common.

When i became pregnant, another woman in Kibera advised me to get an abortion. I did not want to disclose this information to my mother or anyone. Since abortion is illegal, I decided to look for backstreet providers who helped me induce the abortion. Afterwards, I developed serious complications that I could not even walk. My mother came to know of my story and she started taking care of me. At that point, my family started suffering again because I was their main bread winner. I could not visit a health facility for medical check-ups because I feared being arrested if it was discovered that I had procured an abortion. This kept me locked in the house for about 3 weeks but the situation became worse. At that moment, my mother was forced to take me to Kenyatta National Hospital for medical examination and treatment. There, I received a post abortion care and was discharged from the hospital after one week. It was not easy for my family to pay for the hospital bills and I can say that if someone wants to procure abortions, they should only do that from qualified providers".

About 20% of the respondents admitted that abortion was not a bad thing as long as it was done correctly. They argued that if a woman/girl had an unwanted pregnancy, the only rescue

was abortion; instead of giving birth to unwanted child and cursing the innocent child the rest of its life. A 34 year old woman in a survey mentioned that; *“If I want to continue with my business, the only thing I can do is to undertake an abortion and move on with my work”*. During FGD session, another woman (a 25 year old) from Makina village pointed out that:

“Procuring abortion during the first three months of conception is not a sin because, a child has not been formed; it is just blood, hence, It is better to do an abortion than to give birth and throw the child in the streets or in the sewer lines”.

Some women in the FGDs mentioned that whether safe or unsafe abortions, all were dangerous. They reported that deaths, haemorrhage, infections and injuries were the major consequences of unsafe abortions. They also mentioned that even in the hospital setup, something could go wrong especially if the health of the woman was not good. A 26 year old woman from Gatwekera village who participated in the survey reported:

“Even if you go to the hospital, abortion is a very dangerous act. Someone can die while in the doctor’s hands. We have heard many people die in hospitals while procuring abortions; hence, I can say that abortion can kill any time”.

Another respondent, a 34 year old woman from Laini saba said that:

“Procuring abortions especially from unqualified doctors can result into issues of cervical cancers. I would not want to perform an abortion from backstreet providers”.

The pain and sufferings that women reported after visiting unsafe providers influenced their abortion choices in the future. One respondent from Gatwekera village narrated her case experience relating to unsafe abortion from unqualified provider as follows:

Case 3: A 28 year old, single woman and a mother of 2 children decided to procure an abortion because she could not afford to take care of another child. She narrated the following:

“When I realized that I was 5 months pregnant, I was financially strained and could not take feed another child, I already have 2 children. I went to a local woman in our village (Gatwekera) and asked her if she could help me procure an abortion for 300/=. She said it was fine with her and asked me to come back in the evening. When I went back that evening; she gave me a concoction and asked me to drink the whole jug, which I did. I slept in a mat. Suddenly, I started having abdominal pains. In a short while I was bleeding heavily. After 2 hours, she gave me water to wipe myself. The pain became intense; I did not know what to do. The woman inserted a sharp metal in my uterus and was pulling out some pieces of flesh. I started screaming because of the pain I was going through. I could not hold it anymore. When the neighbours heard about the noise, they came into that house and demanded to know what was happening; the woman who was performing the abortion sneaked out and left me alone. I asked the people to rush me to the hospital. On our way I convulsed and later collapsed. I did not know what happened. I regained consciousness after 3 days and found myself in Kenyatta National hospital ward. When I asked the hospital nurse what had happened, she explained to me everything and the painful thing she told me was that they had removed my uterus because it was severely damaged. She confirmed to me that I could never give birth again. I was only 24 years at that time. I got well and my extended family discharged me from the hospital. Up to date, I feel the pain of having lost my womanhood due to unsafe abortion. It hurts me the most especially when I know that I am not a woman enough since my uterus was removed. Unsafe abortion is terribly painful and no one should procure an abortion”.

Furthermore, the guilty and shame that is associated with abortion was also mentioned to be one of the factors that influenced women’s choices in regard to abortion. 60% of the respondents termed abortion as a sin and their religions were against abortion, whether safe or unsafe. It was referred to as murder.

Case 4: A story of 18 year old woman from Makina Village which portrays a mixed feeling of guilty and shame after the abortion procedure made her swear never to procure abortion again in her lifetime.

“When I entered in to the clinic to have the abortion procedure, it was not easy as I decided to have it, and it was very scaring. When I saw the metals they were going to use in the procedure I got so scared. I am a Christian-Roman Catholic and I believe that undertaking abortion is not good unless when faced with a difficult problem. However, I had already decided to undertake an abortion because I was not ready to give birth, my boyfriend was not supportive at all. At that time, I did not think of the sin I was about to commit, abortion was the only solution at hand. When I think of it now I feel that I committed a serious sin. My religion is strongly against abortion, it is considered as murder and I do feel that, I killed a human being; I feel I am a murderer. My mother taught me that abortion is a serious sin, because she had undertaken an abortion and she always felt bad and regretted about it. Before she died, she confessed her sin and she was always praying for forgiveness. It has been a bad experience for me and it has never left my mind that I killed another innocent soul. I sometimes experience bad dreams and I see some children crying while am asleep. One of the children tags along me and really cries with a lot of pain. I have been praying for this feeling to get out of me but in vain. A friend of mine advised me to share my story with my church priest but I find it impossible because, the church and all the people who have trust in me will be disappointed, I don't know how I will face them..”

The nature of the pregnancy was also said to determine where a woman would seek abortion services from. It was reported that one of the main striking reasons as to why women and girls procured abortions was due to pregnancy that resulted from two different and competing religions, (Islam and Christians). A 35 year old Nubian woman (key informant) explained that:

“When a woman especially a Muslim woman knows that she has been impregnated by a Christian man, she will always procure an abortion. She will do this in a very secretive manner, that is, through back street providers, so that her fellow Muslims

would not know what happened. There is a lot of stigma attached to a woman who is impregnated by a Christian; in Islam, this woman will be considered as an outcast and she may feel stigmatized while attending the mosque”.

One of the CHWs working on reproductive health in an NGO - Kibera Women Network reported that abortion should be done safely by professional doctors. She admitted that she had come across girls and women who wanted to procure abortions but could not afford safe abortion services; she always referred them as needy people, to Marie stopes Centre in Kibera which performed safe abortion services to them at a lower cost. In fact, the CHW had a book from the Ministry of health- Kenya, where she referred all women with reproductive issues (including abortion requests) so as to be attended to appropriately.

Having friends who were well informed about safe abortion services and who knew the location of the facilities that offered safe abortion services within Kibera was also mentioned to have influenced a woman's choice in regard to seeking abortion services. The following case narrative elaborates further on this point.

Case 5: A story of a 24 year old woman from Makina Village who procured safe abortion from Marie Stopes Center in Kibera termed the process as safe and less painful.

“When my menstruation did not come on time, I told to my boyfriend, I was afraid to be pregnant. He told me not to be scared of anything; he said “you cannot be pregnant because I was ejaculating outside. Your menstruation may be disordered for some reason”. I trusted him and tried to forget thinking of it. However after 3 months, I became sick and went to clinic. The doctor said such symptoms may be signs of pregnancy and told me to take pregnancy test. The test showed that I was pregnant, I was shocked and cried. When I went back home, I confided with a close friend of mine and she advised me to visit marries stopes center in Kibera for further guidance. I came to realize that my friend had procured safe abortion from Marie stopes the

previous year. She asked me to get about Ksh. 6000 and lucky enough, my boyfriend was working and we cost shared the burden of raising the funds. At Marie stopes, I was educated on what was expected of me and counselled. The doctor then performed the procedure on me and I was given some painkillers to take home with me. I did not have any side effects from the abortion, I went back to my normal duties the following day and I can say that safe abortion is good. The only problem is that most women cannot afford to pay for the service”.

It is evident from these narratives and data from other sources that women's attitudes towards abortion influenced where they sought abortion services within Kibera informal settlements. In addition, providers attitudes towards abortion was also said to be a hindrance to women who sought abortion services from them. Some providers termed the abortion procedure as a sin and illegal. They refused to perform abortions even to women who qualified for the services, according to legal framework in Kenya. Some providers also refused to refer women to other providers who could do abortion because; they termed abortion as a sinful act and did not want to be involved with it. This had a negative impact to women seeking safe abortion services.

6.3 Religious beliefs on abortion

Surveys have shown that religion is one of the most significant demographic factors affecting attitudes towards abortion based on the arguments about when life begins (Gleeson, Forde, Bates, Powell, Jones & Draper, 2008). Religious leaders were part of the Key Informants in this study. Three religious leaders responded quite lengthy on abortion questions. A religious leader from the Christian-Roman Catholic at Gatwekera village explained that abortion was strongly forbidden in their religion; it was equated to murder. The Catholics also believes that life begins at conception and therefore, any woman who decides to procure an abortion is killing an innocent soul.

The Christians-protestant leader at Laini Saba village also admitted that their religion was against induced abortion. He said that; *“Women are allowed to use contraceptives but abortion is not considered as a contraceptive method but a sin. Any woman who could be known to procure an abortion could be expelled from church”*.

Similarly, a Muslim head at the main mosque in Kibera at Makina village explained that:

*“Even though a woman has reproductive health rights; she has no right to kill a human being. That is **“Haram”**-illegal. In Islam, a woman can only be excused to abort if her life or that of the child is in danger. This though, has to be approved by a professional doctor”*.

He further explained that according to their religious beliefs, a child is formed in the mother’s womb after 4 months and 10 days. Yet, there are also some Islamic scholars who believe life begins at the conception day. He also pointed out that the Muslims were not forbidden from using contraceptives, but they were encouraged to use their own system of family planning which entailed continuous breastfeeding for two years.

Several other studies have shown that many religious beliefs are against abortion. Don Marquis (1989) supported the pro-life decision based on the fact that foetuses can be victims of abortion in exactly the same way as adults and children can be victims of murder. He argued that what is needed for the wrong of killing is an individual who is deprived of a future of value .A foetus’ future includes everything that is in an adult’s future given that foetuses naturally develop into adults. Therefore it is right to conclude that killing a foetus, abortion, deprives it of the same sort of valuable future that an adult is deprived of (Strong, 2008).

More arguments such as utilitarian thinking which propose that an unborn human is unaware of their being a person and thus morally justifying abortion have been opposed by the likeness of the same argument to the sleeping adult human who is also unaware/ unconscious to their being persons and hence we can conclusively debate the killing of a human being as not being murder (Cox 2011).

This study revealed that all religions were against induced abortion; to them, this was murder. During FGD's and in-depth Interviews, most of the respondents admitted that although their religious beliefs were against abortion, it could not prevent women from procuring abortions. A 32 year old Muslim woman from Laini saba village argued that; *"of course my Islam religion does not allow abortion by all means, but this cannot prevent women from procuring abortions. That is why abortion is done secretly"*. This was echoed by many other respondents who said that although religion was against induced abortions, desperate women still procured abortions.

Religious belief amongst policy makers and providers also plays a role in the failure to prevent unsafe abortions. The influence that Parliament yields, in terms of making favourable laws that would give life to Article 26(4) has been reduced because many Parliamentarians remain influenced by their religious and cultural beliefs when it comes to legislating on this issue. The Parliamentary Hansard records that Article 26(4) of the 2010 draft Kenyan was passionately debated, with many Members of the House vehemently opposing the clause due to their religious backgrounds (KNHRC 2012).

Some of the health care providers termed abortion as illegal and sinful acts and they reported that they try as much as possible to discourage women from procuring abortions by keeping their pregnancies into term. One of the Key informant's (a health care provider) from Kibera Health Centre reported that:

“Abortion is a sin and my religion does not allow me to perform such duties. It is stated clearly in the Bible that abortion is equated to murder. I believe that the government can work to reduce unintended and mistimed pregnancies by providing sex and reproductive education and also by providing contraceptives to women especially in the slums and rural areas. Abortion is not an option and I usually tell women not to procure abortions. I also don't refer them to other providers because; this means that I will be part of the sinful acts”.

This chapter assessed how women's attitudes towards abortion influenced their access to available abortion services in Kibera informal settlements. It is evident from this study that most women viewed abortion as a sin and illegal based from their religious perspective and the Kenyan legal arm. This aspect drove most women to seek for abortion services from unqualified providers. Stigma and family rejection was also said to be very persistent in Kibera slums hence driving women to procure unsafe abortions from unqualified providers. Even if they knew some facilities that offered safe abortion services, most women preferred unsafe abortions to avoid being identified.

Case narratives of women who had procured unsafe abortions from backstreet providers showed that they wished not to go back to such providers in the future; the pain and sufferings that the women went through from unsafe abortions made them swear never to procure any abortions in the future, while others said they would procure safe abortions from qualified providers. Women who procured safe abortions from qualified providers termed the experience as less painful and safe. They viewed abortion as a safe procedure as long as it was done in the right place by qualified providers. Ultimately, mixed feelings of guilt and shame after procuring abortion as reported in the case narratives influenced women's attitudes towards abortion, whether safe or unsafe abortions. Women who felt guilty after procuring abortions said they would never repeat such acts again.

Provider's negative attitudes towards abortion were also found to be a hindrance to women seeking safe abortion services in Kibera informal settlements. Some providers viewed abortion as sinful and illegal acts and this compromised service delivery as well as referral of women to other providers who could perform abortions to women.

Further, religion was also said to be a hindrance to women seeking abortion services; whether safe or unsafe abortion. However, women were not hindered from procuring abortion services due to their religious beliefs. This was one of the factor that drove women to procuring unsafe abortions from backstreet providers to avoid being noticed.

It is therefore clear that the beliefs and attitudes that women have towards abortion will drive them either; not to procure abortions at all, procure abortions from unsafe providers or procure abortions from safe providers. The next chapter will be presenting on the conclusions and recommendations drawn from the whole study.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The specific objectives of the study sought to: investigate the women's understanding of the abortion provisions in the Kenyan constitution, to determine the availability and accessibility of safe abortion services in Kibera and to examine how women's attitudes towards abortion influenced their access to available abortion services in Kibera informal settlements. This chapter presents conclusions and relates them to a theoretical framework that was used in the study in relation to the study objectives. Recommendations were drawn from the main issues that arose throughout the study.

7.2 Conclusions

The first specific objective of this study was to establish the women's understanding of the provisions regarding abortion in the Kenyan constitution. The study findings showed that most women were not aware of the constitutional provisions regarding abortion in Kenya. About 80% (n=40) of the respondents did not know anything at all on the constitutional provisions of abortion. All they said was that abortion was illegal and anyone found procuring abortion could be dealt with by the police. The perceived illegality issue surrounding abortion has the consequence of driving women to procuring abortions from unsafe providers. Therefore, the abortion law in the constitution is not serving its purpose as required.

The second specific objective of this study was to examine the availability and accessibility of safe abortion services in Kibera informal settlements. This study revealed that most of the respondents were not aware of the facilities that offered safe abortion services in Kibera informal settlements. However, for those who had been to health facilities that offered safe abortion services reported that the services at the facilities were good and friendly. In addition, despite the fact that some women knew where the safe abortion hospitals or clinics in Kibera were located, majority of them (60%, n=30) could not access them due to high cost of safe abortion services. This was one of the factors that drove women to procure unsafe abortions from unqualified providers.

The third specific objective of this study was to assess how women's attitudes towards abortion influenced their access to available abortion services in Kibera informal settlements. Most women who perceived abortion as a sin or illegal were torn into two parts; either not to procure abortions or to procure abortions from unqualified providers. Other women termed the stigma and rejections that was associated with abortion as the main factor that drove them to procure unsafe abortions from backstreet providers. More so, for the women who had procured unsafe abortions, they narrated their experiences which involved a lot of pains and sufferings and they reported that they could not advise anyone to procure abortions from unsafe providers. For others, mixed feelings of guilt and shame after the abortion procedure made them swear that they would never procure abortion again in their lifetime. Further, some of the respondents reported that abortion was not wrong as long as it was done in a hospital with qualified providers.

This study also revealed that provider's negative attitudes towards abortion hindered women's access to safe abortion services. Interviews with the health care professionals in

Kibera informal settlements indicated that most health providers were aware of what the constitution provided for abortion but due to their individual beliefs and moral principles, they did not support abortion. Therefore, even if the demand side was met, the supply side was still wanting.

This study further revealed that all religions (Muslim, Catholics and Protestants) were against induced abortion; to them, this was considered as murder. Though, during FGD's and in-depth Interviews, most of the respondents admitted that religion had nothing to do with abortion. Women who wanted to get rid of their unwanted pregnancies could not apply religious doctrines to their desperate situations, they went ahead and procured abortions.

Scheper- Hughes and Lock's analytical framework of 'The Mindful body' describes how the political and social aspects of life and the individual life choices and decisions are interlinked (Scheper-Hughes & Lock, 1987). In this study religion (social body) shapes the societal norms and values on abortion, it also has an influence on the laws passed by government bodies (body politic). The laws and constitution of the country respects and accepts the societal norms and values. That is why the body politic has just created limited provisions under which abortion is permitted in Kenya. Any self-induced abortions that do not qualify in the prescribed provisions are illegal and punishable.

As Scheper-Hughes and Lock described "an anthropology of relations between the body and the body politic inevitably leads to a consideration of the regulation and control not only of individuals but of populations, and therefore of sexuality, gender, and reproduction" (Scheper-Hughes & Lock, 1987:27).

Unwanted pregnancy and abortion are highly influenced and prescribed and dictated by the culture and religion in Kenya. Abortion usually takes place in the girl's/woman's body (her individual body); but practice of abortion is determined by social norms and perception

which is shaped by religion and the law of the country on abortion. That means an individual decisions on the body self/individual body and how she experiences is determined by the social body (societal values, norms and religion), as well as by laws and policies (body politic) prepared by the government and institutions which regulate and control the individual body. According to Scheper-Hughes and Lock's analytical framework, the three bodies; that is the social body, the individual body and the body politic are not separable, and rather all the three bodies influences one another. For instance, the body politic can influence the body self even in terms of threatening the wellbeing and life.

Before Kenya adopted a new constitution in 2010, the previous constitution (body politic) highly restricted the grounds for women to undertake abortion decision. Even with the current constitution, it still does not give all free and unconditional choices to women. It only gives some provisions under which abortion is permitted. Women's access to safe abortion services is also controlled by the economic conditions due to unaffordability of safe abortion services, unavailability of facilities that offer safe abortion services as well as religious beliefs. Again, providers attitudes towards abortion has been a hindrance to women's access to safe abortion services. This study revealed that some providers viewed abortion as murder, this was influenced by their religious doctrines, and hence, even if the MOH guidelines require providers to make referrals to other providers who can offer the services, it was still not well exercised.

It is evident that lack of knowledge on the constitutional provisions regarding abortion in Kenya is a barrier for most women and girls who want to terminate their pregnancies. Few healthcare providers are trained on the full content of the law and most women remain unaware of the law's exceptions. Women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe

abortion services. Evidently, women's attitudes towards abortion influenced the decisions they made in regard to access to available abortion services in Kibera informal settlements.

7.3 Recommendations

1. The findings of this study revealed that most women in Kibera informal settlements do not know the constitutional provisions regarding abortion in Kenya. There is need to create more awareness among public on what the constitution says about abortion and especially women need to be educated on their rights and the legal issues around abortion. Development and use of culturally appropriate information, education and communication materials will facilitate the process of awareness creation. The public should be informed that safe abortion services are available in public health facilities and hence they should not seek the services from unsafe providers.
2. This study found that women's access to safe abortion is determined largely by their ability to afford the procedure and to identify and reach a provider who offers safe abortion services. The study recommends that the Kenyan government should ensure that there are sufficient facilities that offer safe abortion services to women (both public and private) and making sure that the cost of safe abortion is affordable to women especially the poor women in the Kenyan slums and in rural areas.
3. There is need for the Kenyan government to implement the abortion care-related Standards and Guidelines of the Ministry of Health and to come up with a clear legislation and policy statement that would clear the air and remove all doubts in the mind of health workers as to whether or not safe abortion services should be provided in public health facilities. This will require advocacy at the policy level to address the policy gap.

4. This study further recommends that there is need for a comprehensive abortion care training for all health workers so that they understand that their values and beliefs are not the values of the clients. Such training will enable health workers to appreciate that safe abortion services should be provided without judgement and to the best of ability.
5. This study also recommends that, the rate of unintended pregnancy should be minimized by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education.
6. There is need to integrate abortion services with other health services such as maternity package so that availability of safe abortion services is enhanced and hence, creating room for improvement especially in public health facilities.
7. It is necessary to strengthen public-private partnership in reproductive health. This will facilitate referrals so that the private sector will refer to the public sector and vice versa in order to improve access and address issues of conscientious objection among providers.

7.4 Future Directions

This study explored the factors influencing access to safe abortion services in Kibera informal settlements found in Nairobi City. This study recommends that another study be carried out in rural setting to determine the factors influencing access to safe abortion services in such areas. This will help bring to the fore the factors influencing access to safe abortion services in both urban and rural settings in Kenya. There is also need to conduct more research on public awareness of abortion and safe abortion services in Kenya.

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APPENDICES

Appendix I

Questionnaire

Greetings. My name is Edna Nyanchama Bosire, A student in Masters of Arts in Medical Anthropology from the University of Nairobi. I would like to ask you a few questions about Reproductive health and specifically on abortion. I would like to understand what you think, say and do about certain kinds of behaviours related to reproductive health and unwanted pregnancies. This interview will take about 45 minutes. I will use a tape recorder to assist me remember all the data that I gather and all the tapes will be destroyed immediately after transcriptions. I will not use your name anywhere. I will uphold to matters of confidentiality and whatever that we converse will remain between me and you. I'm going to ask you some very personal questions. If you feel that there is any question you are uncomfortable to answer, you are free to refuse to participate and you are free to withdraw from the participation. You will not be penalised in any way if you decide not to participate.

Do you agree to participate?

Yes No

.....

.....

Date

Signature of interviewer

SECTION 1: PERSONAL PROFILES

1. Sex of respondent

Male Female

2. How old are you?

3. What is your marital status?

Married Never married Divorced Widowed

4. Do you have children? If yes, how many?

5. How old are the children?

Less than 5 years

5 years—10 years

above 10 years

6. Who takes care of the children?

Mother (alone)

Mother (with assistance of biological father)

Parents/ grandparents

Other (Specify

7. What is your highest level of education?

Primary

Secondary

College

Other educational facility (polytechnics, short courses, apprenticeship, etc)

8. Are you currently employed?

Yes No

If No, what is your source of income?

9. What is your religion?

Christian- Protestant

Christian-Roman Catholic

Muslim

other

SECTION 2: SEXUAL ENCOUNTER AND TERMINATION OF PREGNANCY.

1. Have you ever engaged in sexual intercourse?

Yes No

If NO move to Q. 6

2. If YES, how old were you during your first encounter?

Less than 12 years

12—14 years

15—17 years

18—20 years

Over 20 years

3. When was your last sexual encounter?

Within the last we

Within this month

2—3 months ago

4 or more months ago

4. Have you ever had unwanted pregnancy? If No, move to Q6.

Yes No

5: If yes, what did you do about it?

Abort Give birth

6. Do you know anyone who has had an unwanted pregnancy?

Yes No

7. If YES, What did they do about it?

8. Why do women procure an abortion?

9. Why do most women go to unsafe providers to abort?

10. Do you know and understand the constitutional provisions regarding abortion in Kenya?

Yes No

11. If YES, which chapter of the constitution? When is abortion permitted?

12. Are there health facilities/clinics in Kibera slums where someone can procure safe abortion services? Yes No

13. If yes, how far are they and how much do they cost?

14. If no, where do women go for abortions and how much do they cost?

15. Do you know Medical abortion methods?

16. In your opinion, how do you perceive abortion?

17. Do you think religion has an influence on access to safe abortion services? Explain.

Thank you for your time

Appendix II

Interview Guide for Focus Group Discussions

IIa. FGD for young women

1. What do you understand by the term contraceptives? Give examples
2. Where are contraceptives obtained from?
3. Do you think it is important to use contraceptives? Give reasons for yes or no
4. What do you understand by the term abortion?
5. Why do women abort?
6. Where do women go to get abortion services?
7. Who pays for the abortion services?
8. What do you understand by “safe abortion” services? Are there safe abortion services in Kibera slums?
9. How much do they cost?
10. What is medical abortion?
11. What factors do you think hinder women from accessing safe abortion services?
12. How does religion influence access to safe abortion services?
13. How do men influence access to safe abortion services?
14. Do you know the constitutional provisions of abortion in Kenya? If yes, what does it state?
15. What is your opinion on abortion?

II b. FGD for adult women

1. Do you think abortion is a problem in your area? How and why?
2. Who are most vulnerable for abortion? Why?
3. What do you think of women getting unintended pregnancy? Who is to blame: the boy/man who made her pregnant or the women?
4. What do you think about women using contraceptives?
5. Where do women obtain contraceptives from?
6. Why do women procure abortions?
7. Where do they procure them (abortions) from?
8. What are “safe abortion” services? Are there safe abortion services in Kibera slums?
9. How far are they and how much do they cost?
10. What is medical abortion?
11. What factors do you think hinder women from accessing safe abortion services?
12. How does religion influence access to safe abortion services?
13. How do men influence access to safe abortion services?
14. Do you know the constitutional provisions of abortion in Kenya? If yes, which chapter and what does it state?
15. What is your opinion on abortion?

Appendix III

Interview Guide for Key Informants

IIIa. Guide for Health Providers and Community Health Workers

1. Why do women procure abortions?
2. Where do women seek abortion services;
 - In the health facilities?
 - In unqualified personnel?
3. What are safe abortion services? Are there safe abortion services in Kibera slum?
4. How far are they and how much do they cost?
5. What is medical abortion?
6. Are the abortion services in the clinics in Kibera friendly to women?
7. What factors do you think hinder women from accessing safe abortion services in Kibera slums?
8. According to you, what needs to be done to prevent unsafe abortion on women in Kibera slums?
9. Do you know what the Kenyan constitution 2010 provide for abortion? If yes, which section of the constitution? What does it state? (If No go to 10)
10. Has the provisions in the constitution made any changes in relation to abortion in Kenya?
11. What role does religion play in regard to unwanted pregnancies and abortions?
12. What is your opinion towards Abortion?

IIIb. Guide for Religious Leaders

1. What is the opinion and stand of your religious institution on contraceptive use by women?
2. Is there any policy or declaration on contraceptives in your institution at this time?
3. Is there any kind of contraceptives for birth control allowed to the believers by your institution?
4. When does life starts in your religious teachings?
5. What is the opinion and stand of your institution on induced abortion?
6. What is the opinion and stand of your institution on miscarriage?
7. Are there any conditions that your institution may allow termination of pregnancy?
8. Is there any official declaration regarding abortion by your institution?
9. What is the source of the teaching on contraceptive use and abortion in your religion?
10. Are you aware on what the Kenyan constitution of 2010 say about abortion?

APPENDIX IV

Interview Guide for women who have procured an abortion (Case studies).

Personal profile

1. How old are you (optional)
2. What is your highest level of education?
3. Are you employed? If yes, is it formal or informal?
4. What is your marital status?
5. Do you have children? How many?
6. Which religious group do you belong to?

Termination of pregnancy

7. At what age did you have your first sexual encounter?
8. Why did you decide to abort? Were others involved in your decision?
9. At what month of pregnancy did you abort? If a delay between finding out and aborting, why did you delay?
10. How did you decide where to go for an abortion service?
11. Who did you ask for help? Did you go alone, or with someone else, who?
12. Did you face any challenges in seeking safe abortion service? What were the barriers?
13. Were you using contraceptives, or tried to prevent pregnancy in another way when you got pregnant? If no, why no, if yes specify the method and what happened
14. Did you abort in a health facility or in any other place? Specify.
15. What was the cost of the abortion service? Who paid for you?
16. What do you understand by "safe abortion" services?
17. What is medical abortion?
18. Do you have safe abortion services in Kibera? How far are they?
19. What is the cost of safe abortion services in Kibera slums?

Services at health facilities

20. What was the treatment from the providers when you aborted?
21. Were you told to go back for check-ups after the abortion?
22. Were you counselled after the abortion and did you receive any post abortion contraceptives?

Opinions:

23. Are you aware of the constitutional provision of abortion in Kenya? If yes, when is abortion allowed?
24. What is your opinion about abortion in general and your abortion experience?
25. Do you think religion influence access to safe abortion services? How?
26. Do you think men influence access to safe abortion services? How?

Appendix V

Informed Consent

Greetings. My name is Edna Nyanchama Bosire; I am a master's student in Medical Anthropology from the University of Nairobi. I am currently carrying out a study on women, investigating on the factors influencing access to safe abortion services in Kibera informal settlements.

This study is directly related to women of reproductive health age (15-49 years) you are one of the women who are selected to participate in this study. You are humbly requested to participate in this interview. I am going to ask you some very personal questions, your participation in this interview is completely on voluntary basis and you have the right to refuse or withdraw from the participation when I ask a question that you feel uncomfortable with.

The information you provide will be kept confidential. I will not quote your name anywhere; all the recordings that I will make will be destroyed immediately after the transcriptions are made. This study will not provide you any direct benefits, but the information that you provide is very essential, not only for the successful accomplishment of the study but also for producing relevant information that will help improve and better the life of women in terms of reproduction.

Do you have any questions for me?

I have read the above information and agree to participate voluntarily in this study. I understand that I have the right to withdraw from the study at any time I want.

Sign.....date.....