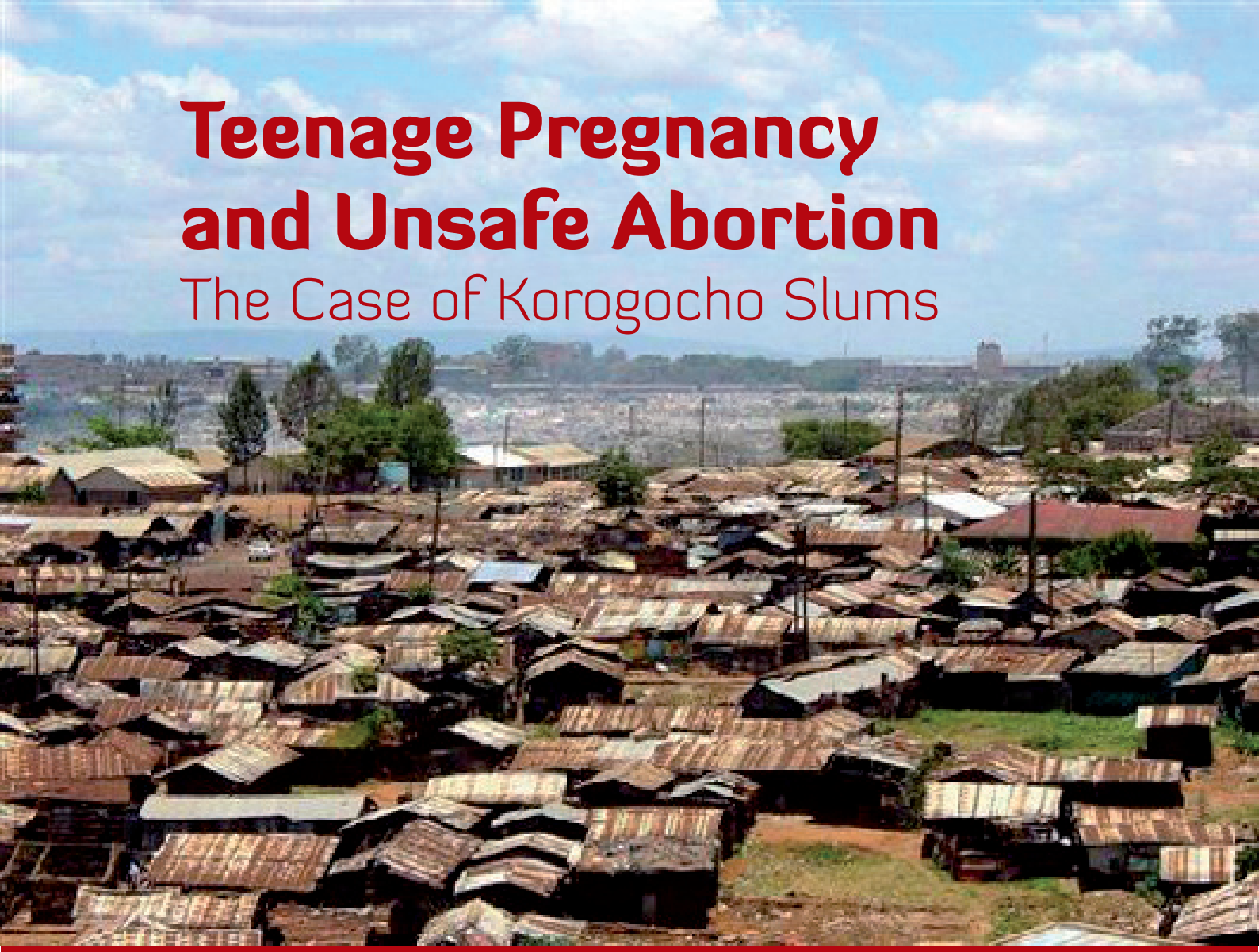
Teenage Pregnancy and Unsafe Abortion

The Case of Korogocho Slums



Final Report

KHRC • RHRA

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KENYA HUMAN RIGHTS COMMISSION

RHRA
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Cover picture *An aerial shot of Korogocho (source: www.begakwabega.com)*

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The Kenya Human Rights Commission (KHRC)

The Kenya Human Rights Commission (KHRC) is a national non-governmental organisation founded in 1992. It has observer status with the African Commission on Human and People's Rights and is a member of the International Federation of Human Rights. The vision of KHRC is "a Kenya that protects and promotes human rights and democratic values". Its mission is "to protect, promote and enhance the enjoyment of all human rights for all Kenyans."

In recognising that organising at the local level is the key to fulfilling its mission, KHRC's work focuses on empowering Kenyans to be agents of change in their communities. The prioritization of sexual and reproductive health rights issues speaks to the organisation's commitment to create a voice and space for all human beings to organise and design strategies to claim and protect their rights.

Overview of the Reproductive Health and Rights Alliance (RHRA)

The Reproductive Health and Rights Alliance (RHRA), which was formed in July 2004, has continued to lead advocacy efforts in Kenya to improve the legal, social and political environment for reproductive health and rights, including safe abortion care. The RHRA advocates for reforming outdated laws and policies that restrict access to safe abortion services, which contribute to the high maternal morbidity and mortality arising from complications of unsafe abortion.

The RHRA believes that:

- sexual and reproductive rights are human rights;
- every woman has a right to the highest attainable standard of health, to safe reproductive choices and to high-quality health care, including the right to safe abortion services where needed;
- no woman should die from complications of unsafe abortion; and
- the government has an obligation to save women's lives.

The RHRA membership has remained constant over the years, with the roles of individual member organisations complementing those of the others to form a robust and vibrant team.

- **The Center for the Study of Adolescents (CSA)** brings many years of experience working with adolescents and youth. CSA also provides leadership in documentation and dissemination of information for advocacy.

- **The Coalition on Violence Against Women (COVAW)** has established itself as the leader in working with opinion leaders and also leads the RHRA's rapid response team.

- **The Federation of Women Lawyers (FIDA-Kenya)** provides leadership in the area of human and women's rights, and legal support and guidance.

- **The Kenya Obstetrics and Gynecological Society (KOGS)** is playing a key role in research to support advocacy efforts and in building the capacity of providers to provide safe abortion services.

- **The Kenya Medical Association (KMA), National Nurses Association of Kenya (NNAK), KOGS** and **FIDA**, all membership associations, have an influential and credible membership that is critical in advocating for change. These organisations have strengthened efforts to motivate their membership through values clarification workshops and presentations at various forums. In addition, KMA, KOGS and NNAK, the professional health associations, are focusing on training health providers in the provision of safe abortion services within the current law, and also developing service delivery standards and guidelines for provision of care. They are supported in this area by *Reproductive Health Services (RHS)*.

- **The Kenya Human Rights Commission (KHRC)** presents the voice of the human rights community. Their work with the Mock Abortion Tribunal in June 2007 placed the abortion dialogue high in the public consciousness and was widely covered in the media. RHRA continues to work to build on and sustain the momentum from the tribunal.

- **PPFA** and the Africa Regional Office of the **International Planned Parenthood Federation (IPPF)** provide leadership and technical support.

The RHRA has partnered with many local and international organisations that are not members of the RHRA but form part of the growing "Friends of the RHRA" to strengthen its advocacy capability in implementing a five-year strategy (2006—2011).

Executive Summary

The Kenya Human Rights Commission (KHRC), in partnership with the Reproductive Health and Rights Alliance (RHRA), commissioned this case study as part of its campaign to publicise the negative effects of criminalization of abortion in Kenya. This study was therefore commissioned with the objective of drawing linkages between the general observations made during this campaign: that there is a link between high incidence of unsafe abortions among teenage girls and lack of access to comprehensive reproductive health care and lack of awareness about reproductive rights. The Korogocho slum was selected because of its unique geographical location in Nairobi and its large population of young people who struggle to survive in the face of abject poverty, poor sanitation and minimal infrastructure.

Specifically, this study compiled and reviewed the issue of teenage pregnancy and the high incidences of unsafe abortion in Korogocho slum in Nairobi. The findings of the study show that there is a need for urgent action to deal with the health, social and economic implications of unsafe abortion in Korogocho, which have become a major human rights and public health concern. Further, there is a need to focus attention on ethical responsibility to provide life-saving care to girls who have undergone unsafe abortion.

The purpose of the study was threefold: to emphasise the magnitude of (unsafe) abortion in Kenya, and the human rights consequences of limited access to safe reproductive health options by using Korogocho as a population sample; to raise awareness about the need for expanded access to safe, affordable reproductive health services and options; and to formulate strategies for advocacy at all levels of the society for the creation of a social, legal and political environment that will make this achievable.

This study turned out to be a unique forum in which different nascent issues around teenage pregnancy, such as stigma, were addressed. During the data collection process, the young women of Korogocho spoke for themselves on the issue. The key lessons learnt during the study were:

1. Abortion is prevalent in Kenya despite legal constraints or religious teachings.

2. Abortion is procured in unsafe and unsanitary conditions that put the lives of young women at risk.

3. Adolescents engage in sexual behaviour that puts them at risk of unwanted pregnancies and sexually-transmitted infections, with or without provision of contraceptives.

4. Abortion is perceived as a practical solution to a problem (unwanted pregnancy) that is compounded by social stigma and the economic environment. In the minds of young women, the ideologies of anti-choice and pro-choice movements about when life begins are inconsequential.

The KHRC and the RHRA advocate the following:

1. Provision of unbiased information on sexual and reproductive health;

2. The need for adolescent-friendly reproductive health services;

3. Advocacy for abortion rights based on the needs of young women, not on philosophies and ideologies;

4. Revision of restrictive legal frameworks and policies that encourage young women to procure unsafe abortions;

5. Careful messaging in adolescent behaviour change programmes; and

6. Most importantly, haste in applying the above recommendations. Young women will continue to die as a result of unsafe abortion until practical solutions are found.

Abbreviations/Acronyms

ARH&D	Adolescent Reproductive Health and Development
CEDAW	UN Committee on the Elimination of Discrimination against Women
CRC	Committee on the Rights of the Child
D&C	Dilation and Curettage
ECSAOGS	East, Central and Southern Africa Obstetrical and Gynaecological Society
FIDA-K	The Kenyan Chapter of the Federation of Women Lawyers in Kenya
HIV/AIDS	Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
KDHS	Kenya Demographic and Health Survey
KHRC	Kenya Human Rights Commission
KNASP	Kenya National HIV and AIDS Strategic Plan
KSPA	Kenya Service Provision Assessment
MVA	Manual Vacuum Aspiration
RH	Reproductive Health
RHRA	Reproductive Health and Rights Alliance
SPSS	Statistical Packages for Social Sciences
STDs/STIs	Sexually Transmitted Diseases/Infections
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization

Chapter 1
Introduction

1.1 Unwanted Pregnancy and Abortion among Kenyan Adolescents

Unwanted pregnancy and abortion are prevalent among school-going youth in Kenya. In 2003, young women below 20 years of age accounted for 16 per cent of the over 20,000 abortion-related complications treated annually in Kenya's public hospitals[1]. In the same year, of the 42.1 per cent of young people aged 15 to 19 years who reported having their first sexual experience[2], only 11 per cent of young women reported using modern contraception.

Another study conducted by the Ministry of Health in collaboration with the Kenya Medical Association, the Federation of Women Lawyers in Kenya (FIDA-K) and Ipas Africa Alliance, indicates that about 316,560 abortions – both spontaneous and induced – are performed in the country each year, causing an estimated 20,000 women and girls to be hospitalised with related complications. This translates into a daily 'abortion rate' of about 800 procedures and the death of 2,600 women every year.[3] The study also revealed that about 1 per cent of women admitted to public hospitals were dying from abortion-related complications and nearly 50 per cent of abortions occurred in women aged between 14 and 24. The Kenya Demographic and Health Survey (KDHS) of 2003, a study carried out by the Central Bureau of Statistics in partnership with the Ministry of Health and MEASURE DHS+[4], revealed that 48 per cent of the abortions occur in girls aged between 14 and 24 years; the same study further revealed that 57 per cent of the women and girls who procured abortions come from urban areas.

[1] Gebreselassie H, Gallo MF, Monyo A, et al. The magnitude of abortion complications in Kenya. BJOG: An International Journal of Obstetrics and Gynaecology. (2005)

[2] National Coordinating Agency on Population and Development (NCAPD 2003)

[3] Ministry of Health, Kenya Medical Association, Federation of Women Lawyers in Kenya and Ipas Africa Alliance (2004) A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya

[4] MEASURE DHS+ is a USAID funded programme which is designed to assist developing countries to collect data on fertility, family planning and maternal and child health.

Reproductive health and rights have been conceptualized under several human rights instruments which Kenya has ratified.[5] These instruments seek to entrench gender equality by stemming out discrimination against women and guaranteeing comprehensive rights to women, including: the right to take part in the political process; to social and political equality with men; to control their reproductive health; and to put an end to female genital mutilation. In spite of these instruments, abortion is restricted in Kenya and only applies in very limited situations, that is, where the continuation of the pregnancy poses a threat to the life of the woman.

These restrictive provisions have, however, not curtailed abortion but have instead driven this practice underground. Many procedures are conducted under unsafe conditions and carry a substantial risk of maternal morbidity and mortality. It is estimated that unsafe abortions account for 33 per cent of maternal deaths in Kenya, with 5,000 women dying annually from complications arising from abortions conducted in unsanitary conditions by unqualified people. The KDHS estimates the national incidence of unsafe abortion to be 44.7 per cent.[6] Other than death, young women who procure unsafe abortions run the risk of suffering from complications and side-effects, the most common of which is post-abortion sepsis. Others include infertility, hypertension and haemorrhage.[7] Most of these conditions affect adolescents and young women.[8] According to the World Health Organization (WHO), African adolescents are also particularly at risk because they are more likely to delay abortion decisions and to seek unsafe providers than adult women.[9]

Studies also indicate that women likely to procure abortions are not only young, but are poorly educated and of low economic status. According to a study conducted at the Kakamega Provincial General Hospital in 2002,[10] that tracked 400 randomly selected files from the admissions in the gynaecology ward for socio-demographic factors, diagnosis, treatment and outcome, of the 80 per cent of acute admissions, 42.5 per cent were abortion-related. The study

5 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), Universal Declaration of Human Rights (UDHR), International Covenant on Economic, Social and Cultural Rights (ICESCR), UN Committee on the Elimination of Discrimination against Women (CEDAW), etc.

6 Source: KDHS 2003

7 Oyieke, J.B.O., Obore, S., Kigondu, C.S. 2006: Millennium Development Goal #5: A Review of Maternal Mortality at the Kenyatta National Hospital, Nairobi

8 Wamwana, E.B., Ndavi P.M, Gichangi P.B, Karanja J.g., Muia E.G. 2006: *Socio-demographic characteristics of patients admitted with gynaecological emergency conditions at the Provincial General Hospital Kakamega*

9 Olukoya, A.A., et al. 2001. Unsafe abortion in adolescents. *Special Communication from the World Health Organisation. International Journal of Gynaecology and Obstetrics* 75(2): 137—147

10 *Supra* note 8

also found that the most common side effects of the unsafe abortions treated were pelvic inflammatory disease (24 per cent) and pelvic abscess (10 per cent). Furthermore, the study revealed that 45 per cent of the patients were teenagers (mean age 17 years), 86.5 per cent were unemployed and a majority had only attained primary level of education.

The Government of Kenya estimated the annual cost of treating abortion-related complications to be KES 18 million or about USD 230,000.

World Bank experts believe that high unsafe abortion rates may be partially attributable to the continued extra-official expulsion of pregnant students from Kenyan schools.[11] According to a study by the Centre for the Study of Adolescence, a non-governmental organisation that works on issues related to teenage reproductive health, an estimated 13,000 Kenyan girls drop out of school annually as a result of pregnancy, and about 17 per cent of girls have had sex before the age of 15. The drop-outs occur in spite of a 'Return to School' policy put in place by the Ministry of Education that allows girls to stay in school until delivery, and resume their studies as soon as they are strong enough to do so.

Other reasons attributed to the high levels of unwanted pregnancy and abortion are pervasive barriers to access contraceptives, coupled with misleading, inaccurate or incomplete information on reproductive health rights among the school-going youth. The Convention on the Elimination of Discrimination against Women (CEDAW) requires state parties to eliminate discrimination against women in education and to provide women equal access to education materials and advice on family planning.[12] It further protects the right to access information on family planning.[13] In 2007, the Committee on the Rights of the Child (CRC) noted that it was "concerned over the high rates of teenage pregnancies, the criminalization of the termination of pregnancies in cases of rape and incest" and recommended that the State Parties "undertake a comprehensive study to assess the nature and the extent of adolescent health problems and, with the full participation of adolescents, use this as a basis to formulate adolescent health policies and programmes in the school curriculum with particular focus on the prevention of teenage pregnancies, unsafe abortions and sexually transmitted diseases including HIV/AIDS."

[11] Odaga A. and Heneveld, W. Girls and Schools in sub-Saharan Africa: From Analysis to Action (1995)
[12] Article 16.1
[13] Article 10h

Large numbers of adolescents still lack accurate information about family planning and this contributes to the low use of contraceptives among young people. Data from the 2003 KDHS show that 74 per cent of sexually-active teenagers do not use any form of contraception. In the afore-mentioned study of secondary school students, about 50 per cent knew what emergency contraception was, but less than one third knew where to obtain it. Furthermore, 40 per cent of married adolescents did not talk to their spouses about contraceptives. The survey also revealed that educated girls were less likely to marry early and more likely to practise family planning.

Kenya's Ministry of Education has an HIV/AIDS prevention and sex education curriculum, but no specific classroom time is set aside for it, which leaves schools and teachers to teach the subject at their discretion. In addition, schools in remote rural areas, as well as in low-income urban areas, often do not have the resources or training to teach sex education. In an interview with the Inter Press News Agency, Christopher Barasa, the principal of the Genesis Joy Primary and Secondary School in Nairobi's Mathare area, stated that the school did not "have sex education or HIV education" because the government had not provided any material or training.[14] Even when sex education is provided in schools, lack of adequate training of teachers can lead to adverse effects. For instance, an evaluation of one reproductive health school programme in Western Kenya revealed that school-based intervention significantly reduced students' support for safer sex practices and increased girls' confusion about the timing of their fertile period. [15]

Research also reveals that violence against women also exposes many young girls to unwanted pregnancy and its various consequences. The 2003 KDHS found that 49 per cent of Kenyan women reported experiencing violence in their lifetime and one in four women had experienced violence in the previous 12 months;[16] A survey published by UNAIDS in 2006 found that 83 per cent of Kenyan women and girls reported one or more episodes of physical abuse in childhood and 46 per cent reported one or more episodes of sexual abuse in childhood.[17] Furthermore, a government report shows that a quarter of 12-24 year-olds lose their virginity through some form of force.[18] A majority of the victims of violence are girls: 60

[14] Available at: http://ipsnews.net/africa/nota.asp?idnews=42487 , accessed 25 March 2009

[15] Askew et al, 2004. Available at: findarticles.com/p/articles/mi_6898/is_/ai_n28402560, accessed 25 March 2009

[16] Source: KDHS 2003

[17] Available at: http://data.unaids.org/pub/Report/2006/_GCWA_RE_Violence_Women_Girls_Kenya_en.pdf , accessed 25 March 2009

[18] Source: Kenya National HIV and AIDS Strategic Plan (**KNASP**) 2005/06—2009/10.

per cent of women who have experienced violence reported age-at-first abuse between 6 and 12 years and 24 per cent reported that they first experienced abuse between the age of 13 and 19 years.

The purpose of this study is to examine the current incidence of unwanted pregnancy among young women of reproductive age in the Korogocho slum in Nairobi and to explore the factors associated with it. The approach used in this study was designed to minimize underreporting and to elicit reports of all unwanted pregnancies, regardless of their outcomes. In addition, the study explores women's reasons for not wanting a pregnancy, the barriers they face to effective contraceptive use, and their use of abortion to terminate unwanted pregnancies. Furthermore, it examines the level of risk of unwanted pregnancy and the reasons given by women and girls who are most at risk for not practising contraception.

1.2 The Impact of Kenya's Legal Regime on Human and Reproductive Health Rights

1.2.1 The Right to Life, Liberty and Security of Person[19]

All human beings are born free and equal in dignity and rights and thereby every human being has a right to life. This right is safeguarded by the Universal Declaration of Human Rights (UDHR). The UDHR further provides that no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.[20] Maternal mortality and morbidity is in itself regarded as a violation of a woman's right to life. These high mortality rates can be linked to insufficient availability of comprehensive reproductive health services, lack of availability of safe abortion service and high rate of teenage pregnancy.[21]

1.2.2 The Right not to be Subjected to Torture or other Cruel, Inhuman, or Degrading Treatment or Punishment.

The UDHR and the International Covenant on Civil and Political Rights (ICCPR) denounce torture and inhuman and degrading treatment.[22] State parties are also required to protect children from all forms of abuse under the Convention on the Rights of a Child (CRC).[23] The UN Committee on the Elimination of Discrimination

[19] UDHR Article 3
[20] UDHR Article 5
[21] Concluding Comment of CEDAW Committee on reports of Bangladesh, 1997, Burkina Faso 2000, Dominican Republic 1998, Madagascar, 1994
[22] UDHR Article 5, ICCPR Article 7
[23] CRC Article 34

against Women (CEDAW) has condemned sexual violence, domestic violence, sexual harassment and violence in reproductive health services.[24]

The young women of Korogocho are under threat of violence within their community. They are also subjected to degrading treatment at reproductive health facilities due to their age and sexual activity. Several respondents stated that they sought an abortion to protect the unborn child from future abuse. According to the respondents, since they have little access to resources and economic opportunities, terminating a pregnancy is seen as one way to protect the unborn from a hostile environment.

Clandestine methods of abortion can also be classified as torture as they cause debilitating pain and no pre- or post-abortion counselling is offered. This is directly linked to the following:

1.2.3 The Right to Enjoy the Benefits of Scientific Progress

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. Modern abortion procedures minimise both risk and pain; it has been noted that it is less risky to undergo a safe abortion procedure than it is to have a tooth extracted.[25]

1.2.4 The Right to Decide the Number and Spacing of Children[26]

In protecting the woman's right to decide the number and spacing of children, international law provides that states have an obligation to provide complete and necessary information to women as a means to do so. More specifically, the Convention on the Elimination of Discrimination against Women (CEDAW) requires state parties to eliminate discrimination against women in education and to provide women equal access to education materials and advice on

[24] The right to equality in marriage is also recognized in Programme of Action of the International Conference on Population and Development (1994) principle 9, The Fourth World Conference on Women. Beijing Declaration and Programme of Action 1995 para 274e

[25] J. Nyanjom, 2007, *Desk Review of Studies Carried Out on Abortion in Kenya 2002—2007*, RHRA

[26] CEDAW Article 16.1, Programme of Action of the International Conference on Population and Development (1994). Prin. 8 and the Fourth World Conference on Women, Beijing Declaration and Programme of Action 1995 (paragraph 223)

family planning.[27] It further protects the right to access information on family planning.[28]

1.2.5 Right to Health

Article 14 of the Protocol to the African Charter on the Rights of Women in Africa calls upon states parties to the Charter to ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. Furthermore, the Africa Health Strategy developed and adopted during the 3rd Ordinary Session of the AU Conference of Ministers provides in Article 86 that, *"The health system should mainstream gender into health policy, seek elimination of all forms of violence against women… Amongst other factors, recognizing the morbidity and mortality from unsafe abortions safe abortion services should be included, as far as the law allows…".*

1.2.6 Right to Non-Discrimination and Equality

The CEDAW, under Articles 12 and 16, protects women's health and requires state parties to eliminate discrimination in heath, including reproductive health care. State parties are also required to take all appropriate measures to eliminate social and cultural patterns and practices that perpetuate notions of women's inferiority.[29] On the issue of adolescent sexual health, the ICPD in Cairo in 1994 provides that states should: *"Protect and promote the right of adolescents to reproductive health information and care."* The CEDAW has also implied that as abortion is a medical procedure that only women need, its denial is a form of discrimination.

1.2.7 Right to Privacy

International law protects children from arbitrary and unlawful interference in their family and private life[30] and establishes their right to be free from arbitrary and unlawful interference in their privacy, family, home and correspondence.[31]The right to privacy is violated when young girls are forced to undergo induced abortions in secret because they fear imprisonment due to illegal abortion.

[27] Article 16.1
[28] Article 10h
[29] CEDAW Article 5
[30] CRC (1989); articles 16.1 & 16.2
[31] ICCPR (1966) articles 17.1 & 17.2

1.2.8 Right to Freedom of Conscience and Religion[32]

The right to freedom of thought, conscience and religion encompasses freedom of thought on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others. This provision cannot be derogated from, even in time of public emergency.[33] The freedom to "have or to adopt" a religion includes the right to adopt atheistic views, as well. Article 18.2 bars coercion that would impair the right to have or adopt a religion or belief, including the use of threat of physical force or penal sanctions to compel believers or non-believers to adhere to their religious beliefs.

This right is violated when girls are forced to procure abortions as a result of fear of censure from religious authorities or when the state absolves itself from the responsibility of making gender-sensitive health policies in order to appease religious organisations, a point that will be highlighted later in the study.

[32] International Convention on Civil and Political Rights (ICCPR) Article 18

[33] ICCPR Article 4.2

Chapter II
Data Collection and Results

2.1 Methodology

Study Design and Sample

Data for this study was obtained from a community-based, cross-sectional survey of women conducted in Korogocho slum in Nairobi from 26th of March to 3rd of April 2009. The aim of the study was to understand the negative consequences of criminalizing abortion and the knowledge and use of contraceptives and general reproductive health rights among young women and girls in the slum. Korogocho was selected on the basis of its population of low-income earners and its multi-religious environment. A total of 65 female respondents were successfully interviewed on their experience, knowledge and views on abortion, contraceptives and reproductive health, which forms the basis of this analysis.

Furthermore, the questionnaire design was based on certain working assumptions highlighted by various studies in the introduction. These hypotheses are:

- Persons most at risk of procuring unsafe abortions are young, poorly educated women with low incomes.

- The prevailing reproductive health care system in Kenya is discriminatory towards adolescents and totally disregards men.

Prior to conducting interviews, the research protocol – including the study design, questionnaire, informed consent procedure and means of preserving respondents' confidentiality was reviewed and approved by the Kenya Human Rights Commission.

Procedure

Data was collected using questionnaires[34] and Focus Group Discussions (FGD). The questionnaire was administered during face-to-face interviews in a safe location.

[34] See Appendix

A total of 50 girls were interviewed using this method. Before conducting the study, the interviewers underwent a training session to familiarize them with the structure and content of the questionnaire, the purpose of the study and tips on how to successfully conduct an interview without causing discomfort or distress to the interviewees.

The questionnaire was divided into three major sections:

- The first section dealt specifically with the demographics of the sample. It covered age, parity, marital status, socio-economic status, educational levels and religion of the respondents. To determine socio-economic status, the respondents were asked about their sources of income and where they had children, and who took care of these children.

- The next section of the questionnaire covered sex and reproductive health knowledge of the respondents. Under this section, the sexual history/ activity of the girls, as well as contraceptive use, was recorded. This included questions about the respondents' personal feelings on the use of contraceptives. Both these sections were used to lead up to the issue of abortion so as to set the tone and mood of the interview, as many of the girls may have been reluctant to discuss abortion if it was raised at the start of the interview process.

- The final section of the questionnaire focused on the issue of unwanted pregnancy and abortion.

To start off the discussion, the girls were asked if they were aware of the legal status of abortion. They were then asked if they knew anyone who had an unwanted pregnancy. If they responded in the affirmative, the respondents were then questioned on the circumstances around the pregnancy and action the person took to deal with the unwanted pregnancy, if any. The respondent was then queried if they had ever had an unwanted pregnancy. Reasons were sought as to why the pregnancy was not wanted. Any of the interviewees who responded in the affirmative about terminating an unwanted pregnancy was then questioned on the means they had used to procure an abortion. At this point, the women were allowed to give narratives on their experiences. From this narrative, the interviewer deduced the sanitary conditions of the facilities, the abortion techniques used and any possible side-effects suffered as a result of the abortion..

This third section was carried out in an informal manner and involved administering open-ended questions. The interviewers paid particular attention to incidences of sexual assault. Fifteen respondents were selected for the FDG using the snowballing method of a local self-help group that deals with the issues surrounding unwanted pregnancy and abortion affecting the youth of Korogocho. This interview was unstructured, which allowed the young women to feel at ease. It was set as a round table discussion with the interviewers merely guiding the discussion to ensure that they obtained relevant data required. Questions were asked on the reasons behind the formation of the group, the membership criteria and any other factors that affected the effectiveness of the group.

Data Analysis

Qualitative analysis was performed by combining both manual analysis of facts and the use of Statistical Packages for Social Sciences (SPSS) software as a tool. Responses were sorted according to various demographics e.g. age, marital status, parity, etc. and presented as simple pie charts, percentages and graphs for easier understanding.

2.2 Results of the study

The analysis presented here is a reflection of the responses given in the field during the data-gathering stage via questionnaires. 7% of the questionnaires had not been properly filled out due to missing responses and about 92% were satisfactorily filled with relevant data.

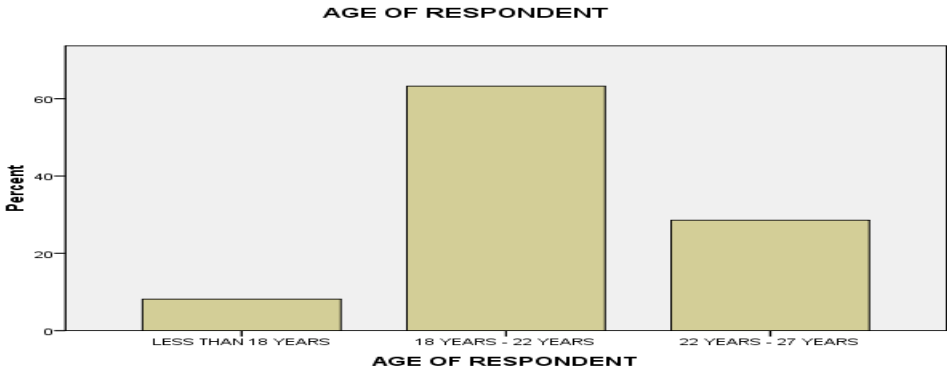
Of the 50 girls interviewed, 92% had procured an abortion. 60% of the respondents were between the ages of 18 and 22 years *(Table 1)* and 56.6% of the total sample reported to have children who depended on them. 16.7% of the respondents were married at the time of the survey *(Table 4)*, 72% were currently unemployed *(Table 3)* and over 70% were not currently enrolled in any type of educational facility *(Table 2)*. A majority (64.8%) were Christians *(Table 5)*. 92% of the total sample claimed to have knowledge of contraceptives and 80% had used some form of contraception during their last sexual encounter *(Table 9)*.

2.3 Personal Profiles

2.3.1 Age of Respondents

As indicated in Figure 1, the majority (about 60%) of the respondents in this particular research were between the ages of 18 and 22 years.. About 24% were between the ages of 22 and 27 years and the rest were less than 18 years.

FIGURE 1



2.3.2 Socio-Economic Status

The majority of the respondents were not enrolled in any educational facility, with a large number having dropped out of school at the primary level. Most of the responses pointed to two major factors contributing to high drop-out rates: pregnancy and/ or unavailability of school fees.

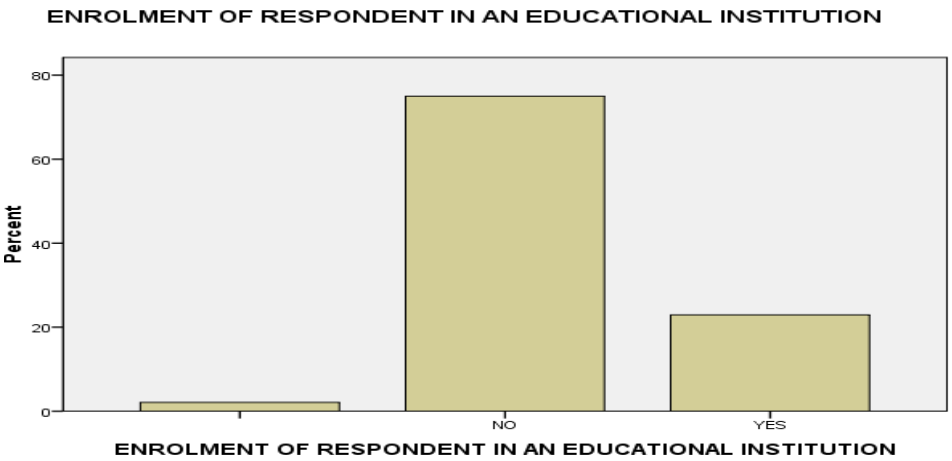
> I dropped out in Class Eight when I got pregnant
> (Single with 1 child, 18—22 years, Muslim)

> I dropped out in Form 3 after my mother passed away so that I could provide for the family.
> (Married with 1 child, 23—27years, Protestant)

A few of the respondents were enrolled at college level while others were enrolled at secondary level. One respondent reported never having been to any formal educational facility.

> I have never gone to school.
> (Single with 1 child, 18—22 years, Muslim)

FIGURE 2



The unemployment rate is very high at 72% as shown in Table 3 below. Most of the respondents admitted obtaining an income through informal businesses, e.g. hawking, waitressing at local bars and others admitted to practising prostitution. They did not regard such work as employment. A minimal number of respondents got assistance from parents/guardians unless they were still enrolled in an educational facility. Fewer still got any help from their partners. This should be compared to the approximately 56.6% of the respondents who have children depending on them as sole breadwinner.

TABLE 1

EMPLOYMENT OF RESPONDENT			
		Frequency	Percent
Valid	No	36	76.6
	Yes	11	23.4
	TOTAL	47	100.0

2.3.3 Marital Status

16.7% of the total sample claimed to be married at the time of the survey while a majority (83.3%) stated that they were single. Marital status did not affect parity, which stands at over 56.6% of the total sample.

TABLE 2

MARITAL STATUS OF RESPONDENT			
		Frequency	Percent
Valid	Married	18	16.7
	Single	90	83.3
	TOTAL	108	100.0

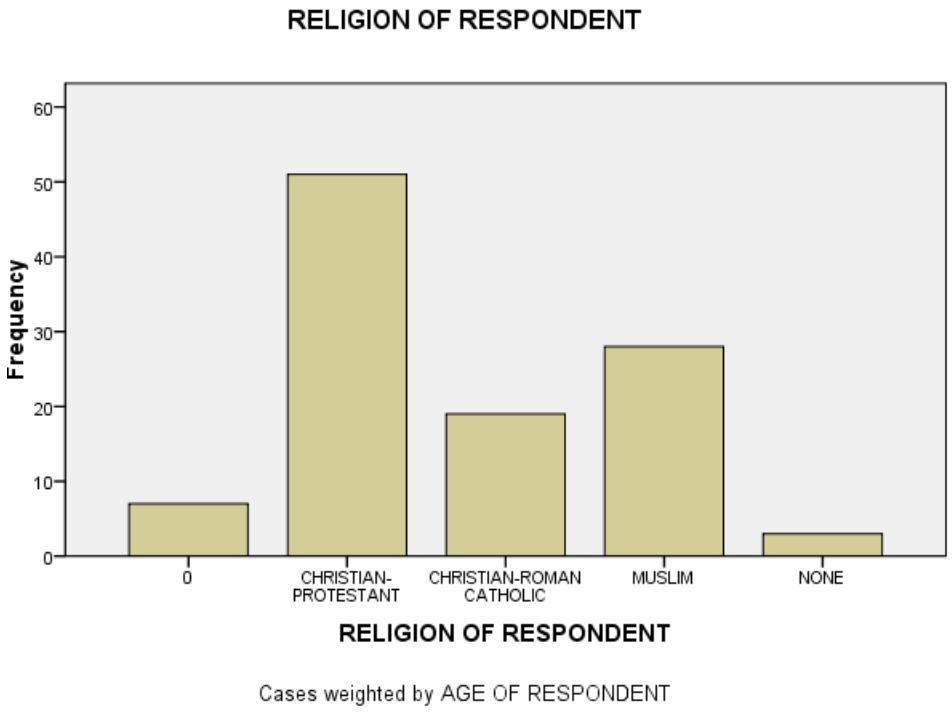
2.3.4 Religion

Nearly half (47.2%) of the respondents were Christian-Protestants and slightly more than a quarter (25.9%) were Muslims. A minority (17.6%) were Christian-Catholics and about 2.8% had no religious leanings

TABLE 3

RELIGION OF RESPONDENT			
		Frequency	Percent
Valid		7	6.5
	Christian-Protestant	51	47.2
	Christian-Roman Catholic	19	17.6
	Muslim	28	25.9
	None	3	2.8
	TOTAL	108	100.0

FIGURE 3

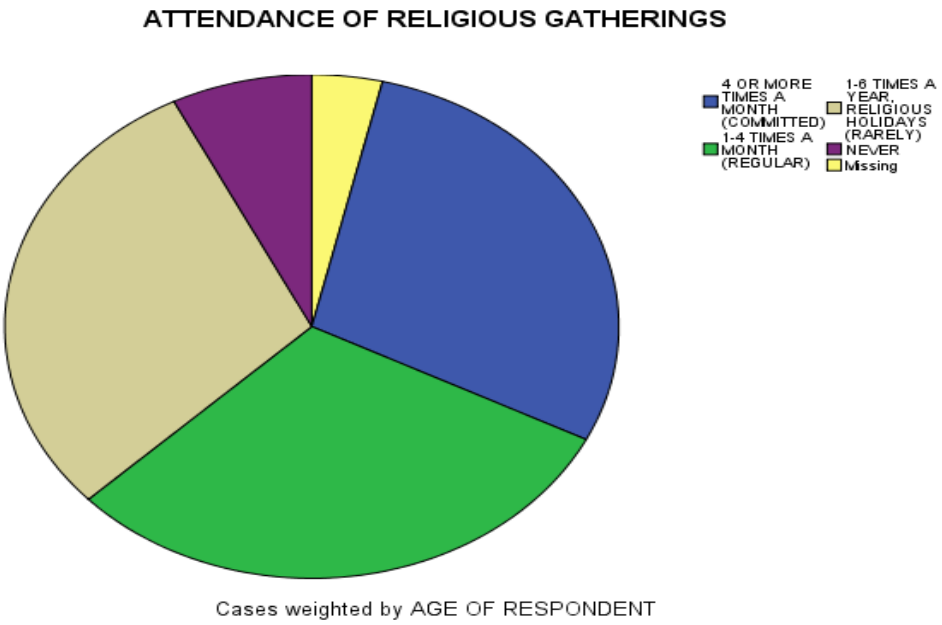


While 30.6% of respondents interviewed admitted to regularly attending religious gatherings, only 7.4% admitted to having never attended such gatherings.

TABLE 4

ATTENDANCE OF RELIGIOUS GATHERINGS			
		Frequency	Percent
Valid	4 or more times a month (committed)	31	28.7
	1-4 times a month (regular)	33	30.6
	1-6 times a year, religious holidays (rarely)	32	29.6
	Never	8	7.4
	Sub-Total	104	96.3
Not Valid	Missing	4	3.7
	TOTAL	108	100.0

FIGURE 4

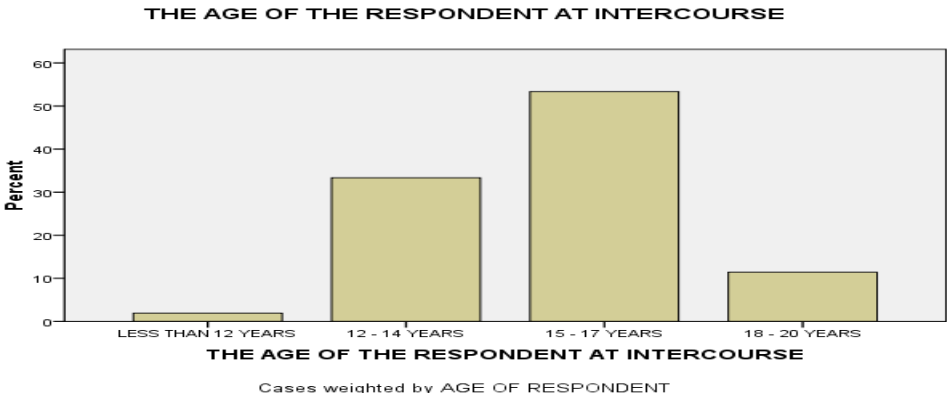


2.4 Sex and Reproductive Health

2.4.1 Sexual History and Activity

100% of the interviewees responded in the affirmative about having previously engaged in sexual intercourse. The graph below depicts the age at which the respondents first engaged in sexual intercourse.

FIGURE 5



32.4% of the respondents first engaged in intercourse between the ages of 12 and 14 years. The majority, 51.9%, first engaged in sexual intercourse between the ages 15 and 17 years. A minority also confessed to having engaged in sex below the age of 12. Several experienced their first sexual encounter as a result of sexual assault.. Some respondents stated that their first experience of sex was as a result of rape by step-fathers, prostitution, sex under the influence of alcohol or pressure from boyfriends.

> During my first time, I was about 14 years of age and in class 8 at the time. My friend took me to this boy's place who she claimed fancied me. He talked to me and I slept with him. I fell pregnant after that and dropped out of school.
> (Single with 1 child, 23—27 years, Roman-Catholic)

The questionnaires revealed that about 35.2 % of the residents had engaged in their last sexual intercourse within the last four or more months at the time of filling in the questionnaire; 29.6% had engaged in sexual intercourse within the last week; 22.2% within the last month and 10.5 % within the last two months. Some of the respondents had more than one sexual partner and a number confessed to practising prostitution.

> I enjoy having fun. Even when I was younger, I used to run away from home to have fun with men. I am now a sex worker.
> (Single with 2 children, 23-27 years, Non-practicing)

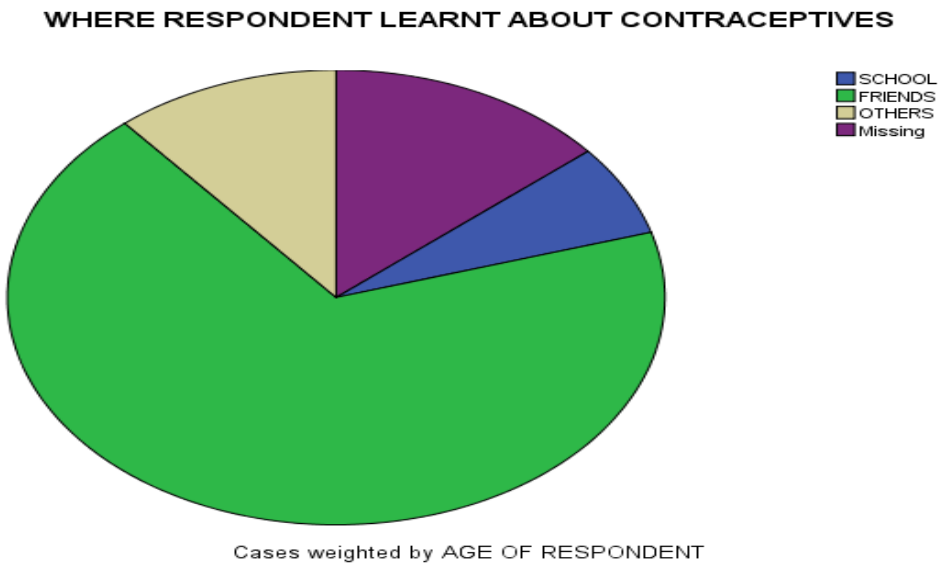
2.4.2 Contraceptive Use

Around 92% of the respondents admitted to having knowledge of contraceptives. The majority (68.5%) said they had learnt about contraceptive use from their friends, while 13.9% refused to give this information or did not know where they

learnt about contraceptives. A few respondents learnt about contraceptives in the maternity hospital (Pumwani Hospital) where they had gone to deliver their children.

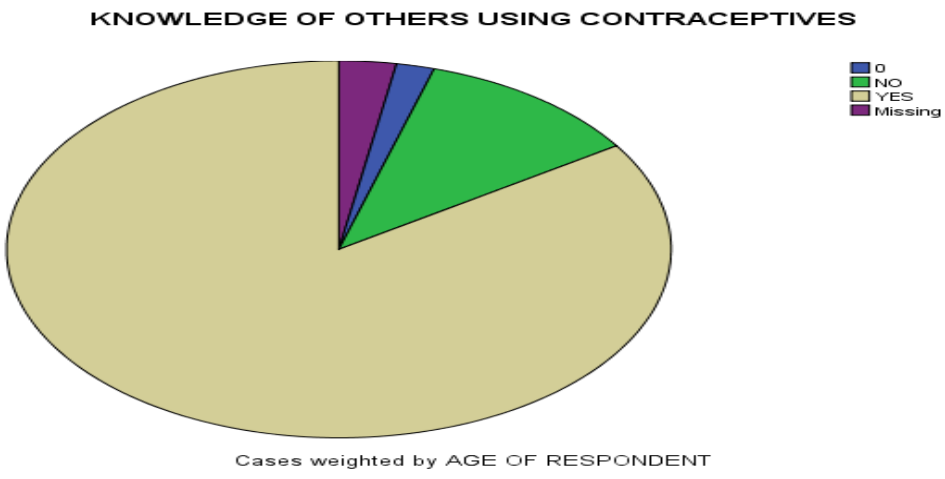
> I learnt about contraceptive use in Pumwani (Hospital) where I had gone to deliver my first child. The nurses there showed me how to use them.
> (Single with 1 child, 23-27 years, Roman-Catholic)

FIGURE 6



A majority (84.3%) of the respondents also admitted to having knowledge of others using contraceptives as shown below.

FIGURE 7



The graphs below show the respondents' preferred contraceptive, type of contraceptive used last and actual use.

FIGURE 8

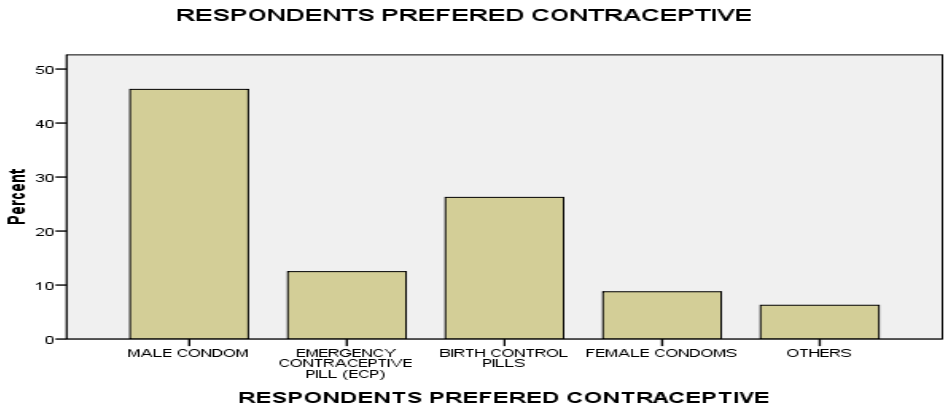


FIGURE 9

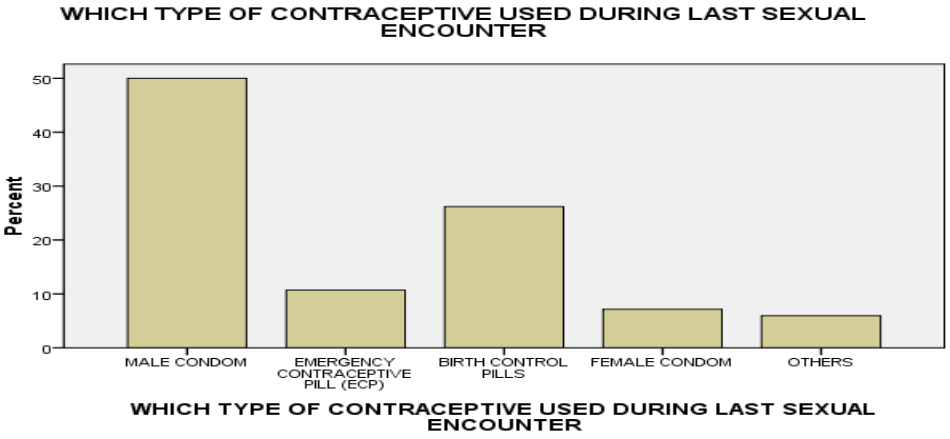
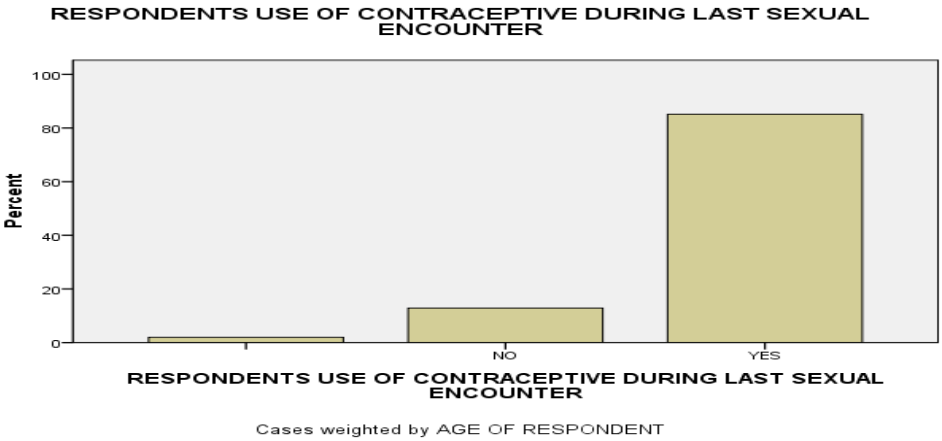


FIGURE 10



Contraceptive use was common among the respondents; over 80% of those interviewed said that they had used contraceptives during their last sexual encounter. The reasons they gave for using the contraceptives was mainly to prevent unwanted pregnancy. Male condoms remained the most preferred form of contraceptive, mainly because the respondents felt that:

- It was safe;
- It had no or minimal side effects compared with other contraceptives;
- It prevented STDs and HIV/AIDS; and
- It was readily available.

Around 38.2% of the respondents, for instance, indicated that they used the male condom during their last sexual encounter, while 34.3% preferred to use the male condom over all other forms of contraception. Birth-control pills followed closely in popularity (19.4%, 20.4%), Emergency contraceptives (9.3%, 8.3%) female condoms (6.5%, 5.6%) and the other forms took the rest.

2.4.3 Reproductive Health Facilities

About 83.3 % of the respondents reported that they were generally treated with respect but reported incidences of rude and unsupportive staff. 56.0% of the respondents were of the opinion that reproductive health facilities were of good quality. 18.0 % believed that the facilities were of average quality while 4.0% found felt that they were inadequate or poor. The quality of reproductive health facilities could be a barrier to access to contraceptives for at least 32% of the respondents who believed that reproductive health facilities were not of good quality.

FIGURES 11

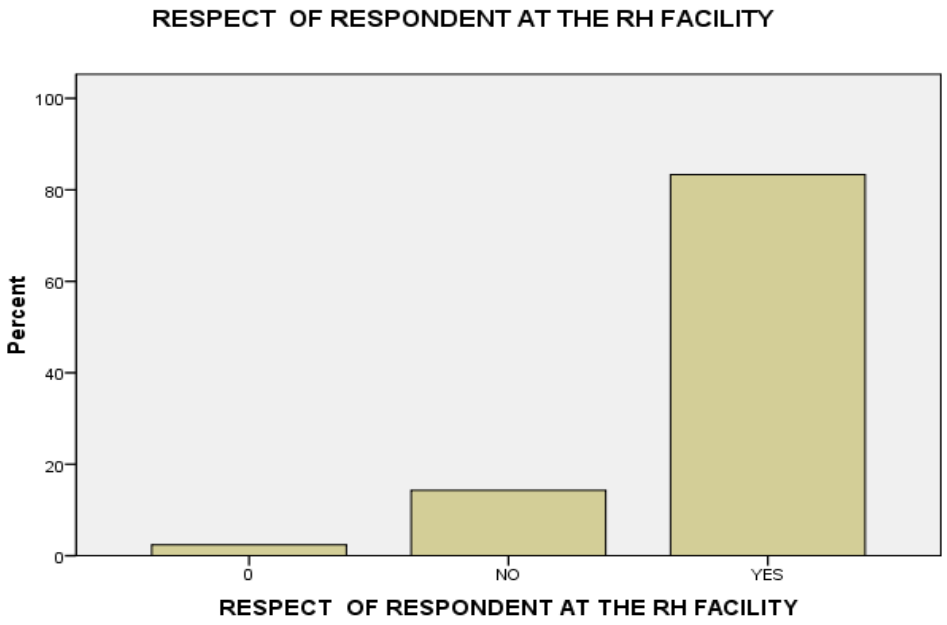
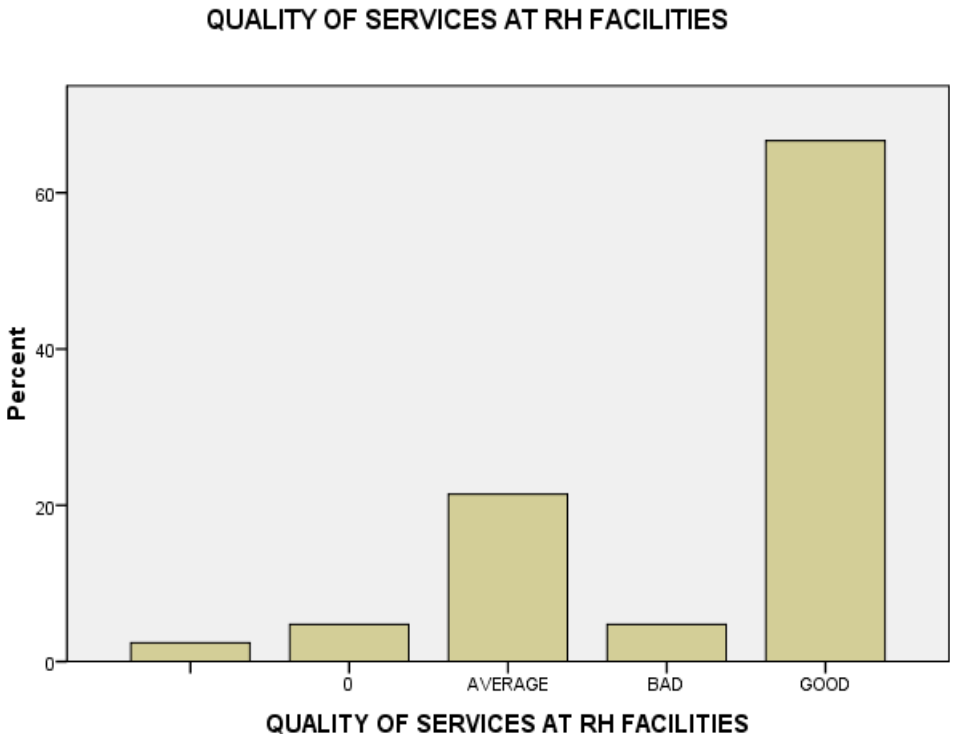


FIGURE 12



2.5 Termination of Pregnancy

The data collected showed that 92% of the respondents had procured an abortion. The rest did not answer the question and therefore it was impossible to determine whether or not they had undergone an abortion. Interestingly, none

of the respondents denied having ever had an abortion. In spite of this, 98% of the respondents were unfamiliar with the legal status of abortion. They believed that abortion was illegal in all circumstances but excused the practice citing the following reasons:

1. In order to continue with their education;
2. Abandonment by the father;
3. Economic constraints i.e. they were not able to take care of the pregnancy or the unborn child;
4. Rape; and
5. Shame

Parents (guardians) and father of the child ranked highest in forcing the respondents to undergo an abortion, followed closely by religious authorities and others. About 40 % of the respondents confessed to having been forced to have an abortion by either their parents/guardians or by the father of the child. Religious authorities also accounted for 10% of the cases reported.

> I am a Muslim. According to our religion, if you give birth while still in your mother's house, your situation will be announced to the entire mosque.
> (Single with 1 child, 18—22 years, Muslim)

> She had no money to cater for a child and her parents were poor. She also did not know the father of the baby as she was raped.
> (Friend of above respondent)

> The father of the baby denied responsibility and I could not afford to bring up a child alone.
> (Single, less than 18 years, Protestant)

> I was forced to have an abortion by my mother. I am Muslim of Somali descent and the father was a Christian of Luo descent. My family could not allow me to have a child with such a person. She took me to a private clinic. After I healed, I was married off to a relative also of Somali descent.
> (Married with 3 children, 23—27 years, Muslim)

> It does not make sense giving birth to your father's child after he raped you.
> (Single, 18—22 years, Protestant)

I am illiterate. I also do not know anything about caring for a pregnancy or a baby as my mother died a year before my pregnancy.
(Single, 18—22 years, Muslim)

2.5.1 Methods of Abortion

Perforation of the cervix by an object to induce premature labour was the most common form of abortion. This accounted for almost 80% of the respondents who had procured abortions. 15% of the respondents used herbs or tea leaves, whilst the remaining 5% were able to procure the services of qualified medical personnel undergoing Manual Vacuum Aspiration (MVA) or Dilation and Curettage (D&C).

My mum took me to a private clinic where a quack inserted a hanger then pulled it out. It was very painful, I don't want to remember.
(Single, 18—22 years, Non-practicing)

My mum bought for me some Maasai herbs which she boiled and gave me to drink.
(Single, less than 18 years, Roman-Catholic)

I had the termination at home. I bought 3 packets of tea leaves, boiled them and drunk the concoction.
(Single, 18—22 years, Muslim)

I went to a private clinic where I was given some medicines to swallow to terminate the pregnancy, then another course of medication to clean the uterus because I wanted to go back to my work as soon as possible (sex worker).
(Single with 1 child, 18—22 years, Roman-Catholic)

It was a shanty in Mukuru Kwa Njenga slums. It was dark, dirty and the bed was a piece of carton. The tools were rusty. He pierced a hole in my uterus, then scraped out the foetus.
(Single with 1 child 18—22 years, Roman-Catholic)

I went to a private clinic where the practitioner inserted a pipe into my cervix and attached a drip for inducing labour. I slept over at the clinic and was released the following day.
(Single with 2 children, 23—27 years, Protestant)

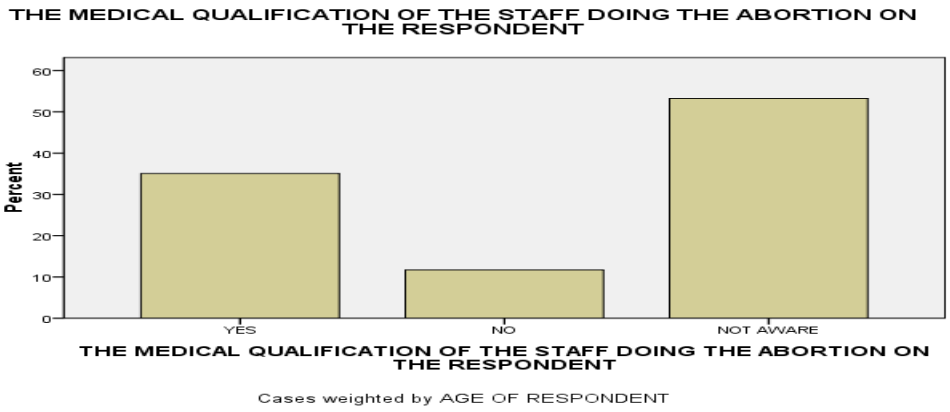
I went to a Government clinic. A machine was inserted in my vagina and sucked out the contents of the uterus. Since I was unconscious after the procedure, I was given bed rest for 2 hours.
(Single with 1 child, less than 18 years, Non-practicing)

I went to a Mzee shown to me by a friend. He put a pipe in my cervix. I went back home. I removed the pipe and the baby got out. I disposed of it. It took about 10 minutes. It was extremely painful.
(Single, 18—22 years, Protestant)

2.5.2 Qualification of personnel

Most incidences of illegal abortions are carried out by persons with formal and informal qualifications. About 53% of the respondents were not aware of the qualifications of the practitioners who offered them abortion services. Only 33% were aware of the qualifications of the persons who were offering them abortion-related services. The rest admitted to having no knowledge of the practitioners' qualifications.

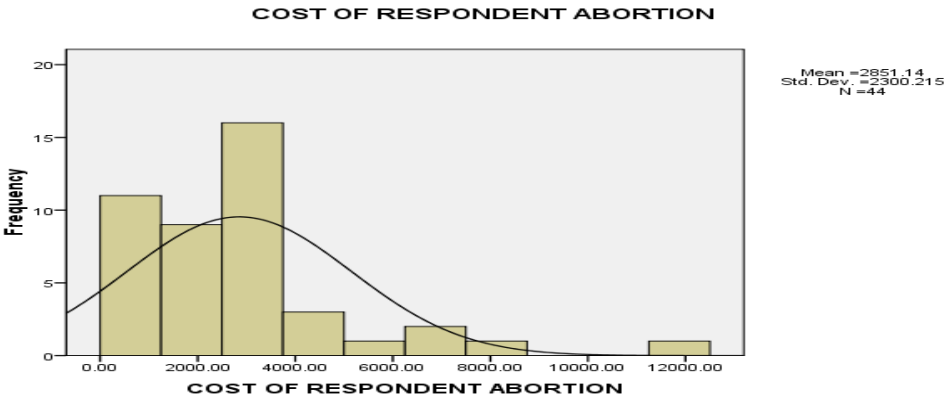
FIGURE 13



2.5.3 Abortion Costs

The cost of performing an abortion is varied, with some spending as low as Kshs.150 for an abortion to as high as Kshs.12, 000. The total cost of carrying out an abortion among the all the respondents amounted to Kshs.125,450. This means that each respondent had spent an average of Kshs.2, 509 on an abortion. Over 72% of the respondents spent Kshs.90,325 on abortion alone. The average cost of abortion was Kshs.5, 000.

FIGURE 14



The respondents obtained the necessary funds for the abortion through several means, with a majority stating that they borrowed money from friends or used an excuse to get money from employers. Parental assistance mostly occurred in cases where the girl was coerced to undergo the procedure. A minority were funded by the man responsible for the pregnancy.

2.5.4 Consequences of Abortion

Despite the fact that the respondents were exposed to high risk of undergoing illegal abortions, most of the respondents did not botherto undergo a follow up; as many as 68% of the respondents who underwent an abortion did not bother to go for a follow up check-up. However 69% of the respondents were well aware of the complications associated with abortion through the experience of their friends who had undergone an abortion. Two cases, however, stood out as the girls were harassed and arrested by the police.

> After procuring the abortion, the father of the baby reported me to the police accusing me of procuring an abortion. The police harassed me, demanding me to produce the dead foetus. Since they could not prove that I had procured an abortion, they let me go.
> (Single, 23—27 years, Protestant)

> Two months ago, a girl from the neighbourhood was reported to the police by her neighbours for procuring an abortion. The police beat her and forced her to direct them to where she had dumped the foetus. She led them to the dumpster where she had deposited the foetus. She was then arrested and charged with murder and has been recently released from the Lang'ata Womens' Prison.
> (Friend of interviewee)

FIGURES 15

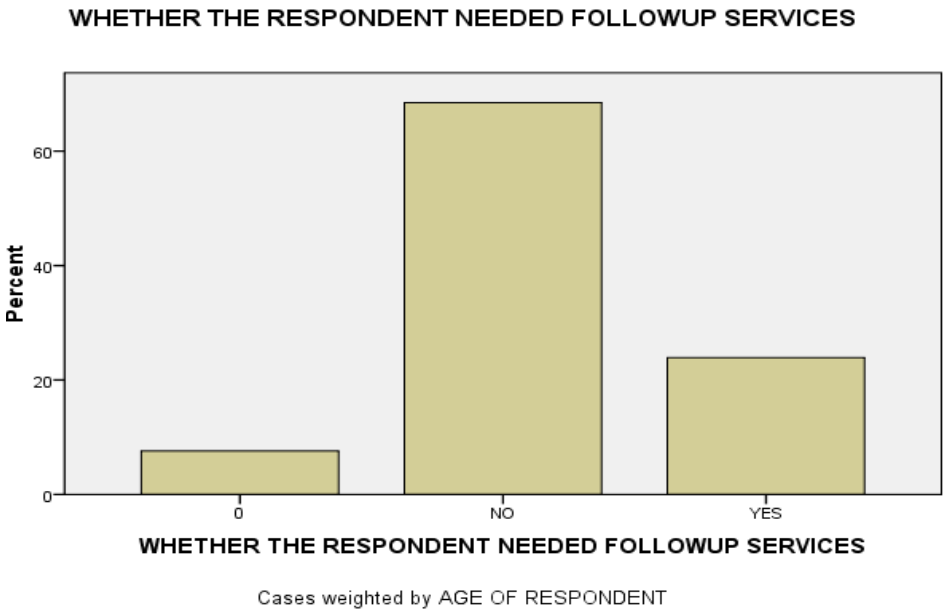
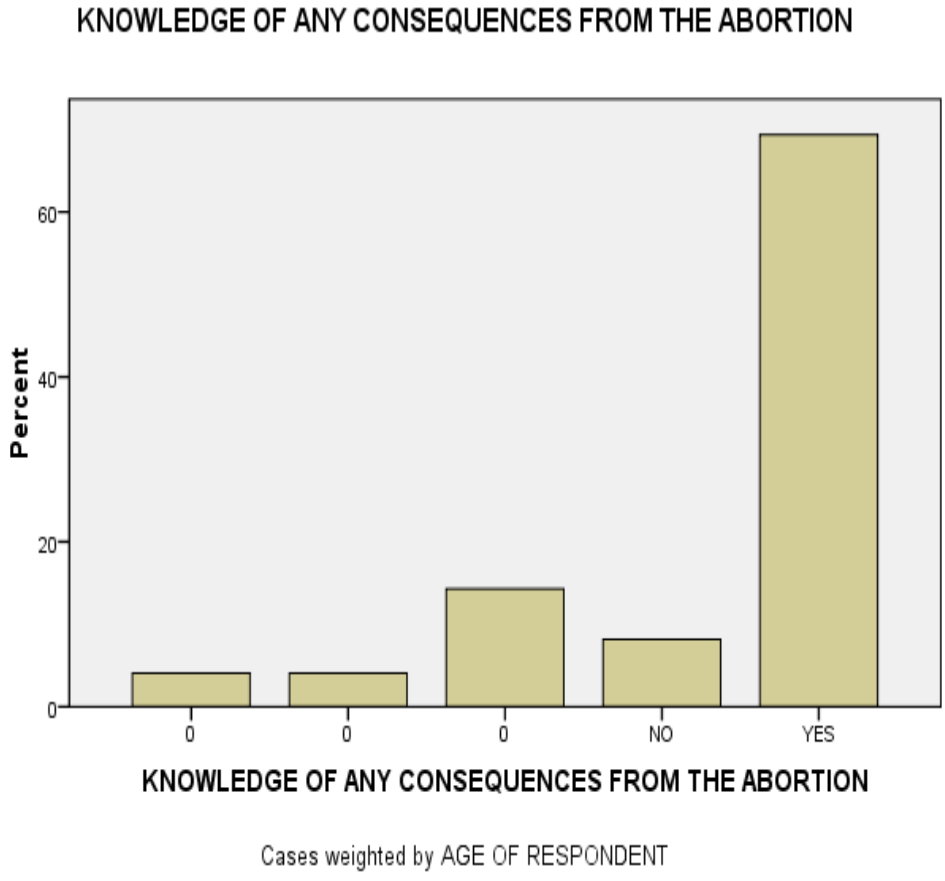


FIGURE 16



The respondents, however, admitted that the abortion had been a painful process and that they had experienced excessive bleeding before healing properly. Other consequences they identified were cases of damaged uterus and sometimes death. This may be attributable to the low levels and/or no qualifications of the abortion practitioners. Most respondents reported lack of anaesthesia and lack of pre-abortion as well as post-abortion counseling and care. In most cases, post-abortion care often amounted to doing the procedure again in cases where the foetus had failed to abort or if the respondent suffered excessive heamorrhage. In one extreme case, the respondent admitted to enduring an entire week of pain before the contents of the uterus were expelled.

> I went to a chemist in Kibera where I was given pills to take. After swallowing them, I was in pain for a week. Finally the contents of the uterus were expelled. The chemist had prescribed some paracetamol tablets to help with the pain.
> (Single, 18-22 years, Protestant)

Other extreme cases were as follows:

> My friend works in Dubai. She was recently in Kenya where she sought to have an abortion. I took her to a place that I knew she could get help. It was a private clinic. The procedure went on smoothly at first, the cervix was perforated and medication to induce labour was given. However, the foetus was not expelled. My friend was in extreme pain. This lasted for hours and hours. At last, the foetus died and the doctor had to perform an emergency Ceaserian section to extract the foetus. My friend is back in Dubai, but I am not aware of any other complications that may have arisen.
> (Friend of Interviewee)

> My abortion procedure was ordinary. My boyfriend took me to the clinic, and the doctor performed the procedure. After two weeks or so, I began experiencing increasingly painful cramps. One day, I just collapsed in class- I was in college at the time- and was rushed to the hospital. The doctor examined me and told me that the foetus I had aborted had not been completely cleaned out. He went ahead and cleaned my uterus and I was discharged into the care of my guardians, my aunt and uncle. They were very distressed and disappointed but they promised not to reveal my situation to the rest of the family.
> (Single, 18—22 years, Protestant)

No psychological trauma was reported by the respondents. The interviewers did not note any obvious display of trauma during the abortion process.

Chapter III Discussion

As confirmed by previous surveys,[35] women at risk of unwanted pregnancy and unsafe abortion fall between the ages of 14 and 27 years. These women are mainly from urban areas, of low income and with little or no formal education.[36] According to the analysis of the respondents' sexual histories, a majority of the girls lost their virginity between the ages of 15 and 17 years. This study also reveals the pervasiveness of sexual violence against women in the community. Even when not explicitly stated, some of the respondents' narratives pointed to possible sexual assault. Sexual violence has been directly linked to the spread of HIV/AIDS and by extension, unwanted pregnancy.

3.1 Pervasive Barriers to Accessing and Successful Use of Contraceptives

Kenya has one of the oldest family planning programmes in the region (instituted in 1967); according to the Kenya Service Provision Assessment (KSPA) 2004, modern family planning services are available at 75% of all health care facilities in the country. In spite of this, reports of unplanned and unwanted pregnancies abound, and abortion is a widespread occurrence in the country. This study shows that 92% of the respondents were aware of contraceptives, but barriers emerged when it came to successful access and use of contraception, with many of the respondents still experiencing unwanted pregnancy.

1. Religious Reasons

A significant number of respondents cited their religion as a reason why they did not use contraceptives. This was notable among the Muslim and Roman-Catholic respondents. This is not a coincidence as both religions' leaders have

[35] Ipas (2004) A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya and MEASURE DHS+ is a USAID funded programme which is designed to assist developing countries to collect data on fertility, family planning and maternal and child health.

[36] Wamwana, E.B. et al 2002: *Socio-demographic characteristics of patients admitted with gynaecological emergency conditions at the Provincial General Hospital Kakamega*

been vocal in opposing the use of contraceptives.[37] More worrisome though, was the repetition of religious rhetoric on contraception[38] by most of the respondents irrespective of their religious background. When respondents were asked if they would encourage their peers to take contraceptives, most respondents replied in the negative. The most common reason given was that contraceptive use would encourage sexual immorality amongst the youth and that the youth should instead be encouraged to abstain from sex. Compare this with a papal statement made to African bishops at the Vatican by Pope Benedict XVI:

> "It is of great concern that the fabric of African life, its very source of hope and stability, is threatened by divorce, abortion, prostitution, human trafficking and a contraception mentality… contraception was one of a host of trends contributing to a "breakdown in sexual morality"… The traditional teaching of the church has proven to be the only failsafe way."

Pronouncements such as this are dangerous because they fail to reflect the reality of life in slums like Korogocho where sexual abuse, coupled with extreme poverty, have forced women and girls to deal with unwanted pregnancy or to earn incomes through sexually-risky behaviour, such as prostitution. In cases where contraceptives are readily available, sexually active youth may be inclined to not use them, as per religious teachings.

Another form of religious influence was espoused in the quality of reproductive health education provided. One respondent reported having attended a training seminar hosted by the Roman-Catholic Church. The specific content of the training was not availed but she ended up pregnant twice that same year and procured an abortion each time. This raises serious questions on the quality of information passed on by some religious sources.

2. Poor Education on Contraceptives

According to several studies, large numbers of adolescents still lack accurate information about family planning and this contributes to the low use of contraceptives among young people. Data from the 2003 KDHS show that 74% of sexually-active teenagers do not use any form of contraception. In the afore-mentioned study of secondary school students, about 50% knew what

37 PlusNews, Kenya: Muslim clerics declare war on condoms, IRIN, May 12, 2008. Available at: http://www.irinnews.org/report.aspx?ReportID=78160 , accessed on 25 March 2009

38 BBCNews, Pope Rejects Condoms for Africa, BBC, June 10, 2005. Available at: http://news.bbc.co.uk/2/hi/europe/4081276.stm , accessed 25 March 2009

emergency contraception is, but less than one-third knew where to obtain it. This study exposed several gaps in education on contraception.

The respondents associate male and female condoms with contraception, not with STI prevention. When asked about the benefits of contraceptives, most respondents gave family planning as a reason and not for prevention of STIs. The most preferred method of contraception was the male condom. This was due to its ready accessibility and availability. Although respondents knew about birth control pills, such as Femiplan, they generally avoided hormonal contraceptives. This was mainly due to misconceptions about their side-effects. The respondents felt that hormonal contraception was dangerous and would lead to infertility, especially if used by young girls. This view was reflected by many of the respondents throughout the interview process.

Another issue that emerged was of adolescents using contraceptives incorrectly. Most adolescents approach contraception in "Russian roulette" style i.e. they don't use it regularly or every time they engage in sex. Even those respondents who claimed to use the male condom tended to use it when they felt "safe". This means that they avoided using the condoms regularly as a form of contraception. This may be due to the bargaining power of their sexual partners or simply due to the pleasure principle. Regular use of condoms, however, was noted among the sex workers. But even among those who used hormonal methods of contraception, a majority used them incorrectly. Many of these respondents believed that if one used the injectible contraceptive Depo-Provera once, one could go without using any form of contraceptive for a period of six (6) months. Often birth-control pills were used for a month and then discontinued the next month. Some respondents even interchanged the contraceptive devices throughout the year. One respondent experienced two unwanted pregnancies due to this. This demonstrates a lack of information on reproductive health. It is also worrying that some of the respondents got to find out about contraceptives only after they had already given birth. In these cases, health care workers in clinics and hospitals were often the sources of this information.

Publicity also influences the choice of contraception the youth will use. The male condom is most popular due to aggressive advertising campaigns. This is followed in popularity by Femiplan.

The situation is not all dismal. Some respondents reported that they had undergone trainings held in the community. For example, one woman attended a 2-week

training course at the Chief's camp. All in all, the most effective (not necessarily most accurate) mode of education on contraception was oral communication. The respondents shared information with each other and their friends; others even eavesdropped on older women, thereby passing on information about contraception to others.

3. Quality of Reproductive Health (RH) Facilities

RH facilities determine the access, availability and information on contraceptives. According to Dr. Radloff of USAID-Kenya, one in every four women wants to space or limit their births and is not using family planning services.[39] This study highlights the gap between provision of RH services and actual service delivery. Many respondents complained of rude health care staff and condescending behaviour, especially towards young women. One respondent reported reluctance on the part of a staff member of a health care facility to provide contraceptives once she discovered that her husband was opposed to her taking contraceptives.

RH facilities were mainly selected on the basis of cost. Even though government clinics drew the most criticism for disrespectful staff, they were the most attended as they were cost-effective. Private clinics were avoided due to their high price. Another factor that influenced attendance was proximity to the area. Many respondents visited facilities that were closer to home. The study also highlights the misconception on the role of RH facilities. Even where the facilities abound, they were altogether avoided by boys due to the belief that contraception was *Mambo ya Wanawake* (woman's responsibility). Also, no respondent reported regularly attending RH facilities for more than contraception or maternal care. Those who were not on regular contraception avoided the facilities altogether.

Though few and localised, the RH facilities in the area have done a good job in disseminating information about contraception.

4. Other Influences

- **Social Factors**

For some respondents, contraceptive use was determined by their domestic situations. The KDHS 2003 survey revealed that 40% of married adolescents do not talk to their spouses about contraceptives. This was echoed in the study. Respondents reported that their male partners were reluctant to use contraception themselves. Others go to the extent of preventing their partners

[39] U.S Boosts Family Planning with Ksh.1.4 billion, The East African Standard, May 12, 2009

from accessing contraception. One respondent uses the coil as her preferred mode of contraception because it is internal and is therefore not visible to her husband. She does this because her husband disapproves of contraception.

Stigma was also noted as a barrier, especially in reference to attendance of RH facilities. Some respondents actively avoid facilities within their area and prefer travelling to neighbouring settlements like Kayole and Kariobangi for their RH needs. They do this in order to avoid being recognized. They stated that contraceptive use is seen as a mark of sexual immorality in their area. Once a young woman is known to visit an RH clinic, the neighbours shun her. This form of stigma is practised both by members of the community and RH staff. Another form of stigma experienced is towards sex workers by RH clinic staff. The sex worker segment of the sample reported rude and disrespectful behaviour from RH facility staff members. Some even alleged that they had been insulted by the nurses.

- **Capacity**

Capacity refers to the mental state of a person to make informed decisions. This applies to sexual intercourse as well as contraception. In the study, several cases of young girls having sex while under the influence of drugs/ alcohol were reported, and threat of violence against very young and/or under-age girls was recorded. One respondent, for instance, failed to use contraception during her most recent sexual encounter because she was drunk at the time. Another had no time to plan for contraception because she was raped. In such situations, it is almost impossible to negotiate the use of contraception.

- **Education**

The KDHS 2003 survey revealed that educated girls were less likely to marry early and more likely to practise family planning. This was echoed in the study. The respondents who did not undergo formal education were averse to attending RH facilities. They were also more ignorant of the use and benefits of contraception.

3.2 Unwanted Pregnancy and Abortion

This study shows that in spite of the prevailing social attitudes and criminalization of abortion, termination of pregnancies still continues.

- **When does life begin?**

The above question has been the driving force of both the anti-choice and pro-choice camps in the abortion argument. One of the most startling revelations of the study was that the young women were not deterred by religion or by prevailing arguments about when life begins when they decided to procure an abortion. This echoes the findings in previous studies that the rationale behind abortion is pragmatic rather than philosophical or religious.[40] The respondents chose to terminate their pregnancies for several reasons including:

- Spacing the number of children in the family;
- Economic constraints (especially where the girls were abandoned by the men who impregnated them);
- Emotional distress, in the case of rape or incest;
- To continue with education; and
- To mitigate social stigma.

The argument about when life begins did not arise at all during the interviews. The respondents all believed that they were terminating the life of a living being. They simply made a rational choice as to the viability of having a child vis-à-vis the quality of life that the child would lead. With these issues in mind, the risk of unsafe abortion took a back seat. This same attitude was prevalent among their peers who had procured abortions. The attitude was that abortion may be wrong but it is acceptable under certain circumstances. Very few respondents outrightly denounced abortion as a sin.

3.3 Abortion-related Risks and Complications

- **Delay**

The biggest problem noted among the sample interviewed was the delay in procuring the abortions. This problem has also been noted in previous studies, such as one by the WHO which stated that African adolescents are also more

[40] Ipas (2006) Social scripts and stark realities: Kenyan adolescents' abortion discourse. Available at: http://www.ipas.org/Library/Other/Mitchell_CHS_Kenya_youth_2006.pdf , accessed 25 March 2009

likely to delay abortion decisions and to seek unsafe providers than adult women.[41] In this study, a majority of the respondents waited until the second trimester to undergo the procedure. This was due to several factors, but the most important factor was the lack of funds to procure an abortion. Relatively safe methods of terminating an early pregnancy (i.e. surgical abortion) were expensive, ranging from Kshs.8, 000 to around Kshs.12, 000. In contrast, an induced unsafe, non-surgical abortion cost an average of Kshs. 3, 000.

In addition, the archaic abortion procedures applied are contra-indicated in the early stages of pregnancy. Ignorance of modern abortion procedures or safety by both respondents and abortion practitioners was also manifest.

- **Psychological Trauma/ Complications**

No respondent reported any post-abortion mental or spiritual trauma as predicted by religious leaders, the media and the school curriculum.[42] However, the respondents did display symptoms of trauma related to the events leading to the abortion i.e. abandonment by their partners, sexual violence that led to the pregnancy, termination enforced by parent/ guardian, and pain during the actual procedure. These women continue to be sexually active to date.

- **Religion and Abortion**

The Korogocho sample has proven that religion does not bar women from procuring abortions but affects access and use of contraceptives. Over 90% of the sample practised a religion and of these over 30% attended religious services and ceremonies once or more times a week. These women made their decisions based on their own beliefs where there was no coercion. Furthermore, some respondents do not adhere to any religion and therefore compelling them to conform to rules and strictures of popular religion violated their freedom of conscience.

[41] Olukoya, A.A., et al. 2001. Unsafe abortion in adolescents. Special Communication from the World Health Organisation. *International Journal of Gynaecology and Obstetrics* 75(2): 137-147

[42] Otiende et al. 2001: Kenya Certification Secondary Education Social Education &Ethics Exam Review Book, "Young people who procure abortion often end up leading depressed, frustrated, unwholesome and lonely lives which usher them into a further abyss of depravity and drug addiction…A girl will always know and live with the reality that she wilfully smothered and killed her unborn child. It is fairly haunting and dauntingly prickly to one's conscience. Hallucinations, dementia and ultimate madness are the likely consequences for the victims" at p. 26

Chapter IV
Conclusion and Recommendations

4.1 Summary

This study reveals the following about teenage pregnancy and unsafe abortion in Korogocho:

1. Abortion is not a philosophical argument; it is an issue that has a real and dangerous impact on the lives of young women.

2. Young women will continue to procure abortions as a solution to unwanted and mis-timed pregnancy.

3. "Safe" abortions are economically out of reach for most of these young women and hence they have no choice but to procure unsafe abortions.

4. Parents/guardians often force their pregnant adolescents to procure abortions.

5. Information about contraception is scanty and poorly disseminated. There is a dire need for sexual health education.

6. Currently available RH facilities are not adolescent-friendly and are thereby avoided by sexually active youth.

7. Men are noticeably absent. They are unwilling to attend RH facilities and yet still have power over decisions about women's contraceptive choices.

8. Religion does not play a significant role in youth sexuality other than influencing use and access to contraception. In some cases, stigmatization by religious authorities actually drives young women to procure abortions.

9. Women in Korogocho are subjected to sexual violence at an early age. However, while most of this violence is expressed overtly, some of it is covert e.g. sex without capacity, where the girl in legally incapable of making decisions about sex or maybe under the influence of alcohol or drugs.

4.2 Recommendations

4.2.1 Local Solutions

This information was collected during the Focus Group Discussion. This was a round-table discussion with 15 young women belonging to a self-help Ladies' Club in Korogocho.

- **Creation of the Group:**

The club was formed by five young women who had previously procured unsafe abortions. These five had been trained on self-defence techniques like judo, and decided to come back to the community and pass on this knowledge in response to the rising cases of violence against women in Korogocho. These girls also realised that unsafe abortion is a big issue in the area and that the consequences are higher there because the women are poor.

- **Membership**

The club currently has 70 female members ranging between the ages of 14 and 30 years. This age group was identified as the most afflicted by unwanted pregnancy and unsafe abortion in the area.

- **Club Activities:**

The main focus of this club is information sharing. Meetings are held every Saturday at a member's home. They also share their experiences as unsafe abortion survivors. This is done in the hope that young women will make safe and informed reproductive health decisions. The club also acts as a counselling centre. Since all the members have previously had abortions, by speaking about their experiences, they are able to deal with their experiences and move on. Other members have been exposed to sexual violence in one form or another. As members of the club, they are able to deal with their emotional scars.

They also provide guidance to young girls who are sexually active. This advice includes where to obtain contraceptives and friendly RH facilities. In the case of unwanted pregnancy, the club's members will provide information about where

to procure a relatively safe abortion or where one can give up a child for adoption. There is a facility run by Catholic nuns in Embakasi where girls can take their new-borns. The nuns assist young mothers who have given up their children to start a new life somewhere by giving them a small sum of money.

These cases reflect the prevailing situation in the area. Many women have died while procuring abortions. Others resort to taking Omo, Jik, Neem, local herbs and tea leaves to induce an abortion. The club members have information on clinics that will provide alternative abortion-related services. However, the club faces harassment from the local police who attempt to arrest the members for having procured abortions. They also face stigmatization from the community. Because of this, confidentiality is of utmost importance.

Self-defence training classes are also provided to those who are interested.

- **Club Goals**

The club advocates for reproductive health rights, including the right to choice. They believe that all students should be taught sex education while at school as this will increase awareness and prevent unwanted pregnancies and subsequently reduce abortions. To achieve this, the club is in the process of linking up with other organisations with the same goal.

4.2.2 National Policy Implications

The high prevalence of abortion in Kenya, despite legal restrictions, must be addressed in one way or another. Kenya loses 40,000 potential workers to unsafe abortions. Another Kshs.18 million is spent per year by the Government in provision of post-abortion health care. Not to mention the man hours lost in treating a preventable condition. Examining the international instruments side by side with the results of studies such as this, in view of the cost implications, leads us to the conclusion that Kenya has no choice but to review its existing Reproductive Health Policies. Clearly, the Safe Motherhood Initiative has been a failure, nor is the Family Planning policy faring any better. The only solution is to tackle the issue of unsafe abortion at its source rationally and not philosophically.

4.2.2.1 Review of the Adolescent Reproductive Health and Development policy 2005—2015

The 1994 International Conference on Population and Development (ICPD) endorsed the right of adolescents and young adults to obtain the highest levels

of health care. In line with the ICPD recommendations, Kenya put in place an Adolescent Reproductive Health and Development (ARH&D) policy. Broadly, the policy addresses the following adolescent reproductive health issues and challenges: adolescent sexual health and reproductive rights; harmful practices; drug and substance abuse; socio-economic factors; and the special needs of adolescents and young people with disabilities.

The ARH&D Policy provided a conceptual guide to the development of a Plan of Action, which further distinguishes four strategic areas: advocacy; health awareness and behaviour change communication; access to and utilization of sustainable youth-friendly services; and management. However, the policy's reliance on behaviour change may be its shortcoming. As realised by this study, the youth seem to absorb the behaviour change rhetoric but do not actually implement it. Safer sex practices have been touted in the country for years but these do not do enough to address the actual power balance between the sexes. Men remain the power brokers when it comes to contraception use.

The implementation strategy should include the incorporation of new information on issues affecting adolescent health, such as this study, as it is released. This will help inform the process to be more realistic and help it shift with the prevailing situation. There is a clear need for reproductive health education both in the school curriculum and other informal sources. This education should be structured and objective without necessarily leaning towards moral standards determined by the few. It would provide clear and concise information on sexuality, contraception and abortion. Other informal sources of this information should be used to reach those who do not pass through the formal education system, such as barazas, posters, advertisements on television and radio, etc. Publicity is a powerful means of communication as was revealed in this study.

As part of the policy, the government should launch various adolescent-friendly RH facilities. These should be designed in a way to reach adolescents in marginalised areas, as well as those in protected/ closed societies. The respondents in the study echoed a need for accessible, comprehensive care provided in confidence by non-judgmental staff with good counselling and communication skills. One way in which this could be achieved is to adopt the South African "Going for Gold" programme.[43] In this model, only clinics that achieve the set minimum standards on provision of health care are accredited. These standards include:

[43] Available at: http://74.125.95.132/search?q=cache:AfnBWoJQ6SgJ:www.who.int/reproductive-health/publications/cah_docs/cah_02_14.pdf+reproductive+health+services+south+africa+adolescents&cd=1&hl=en&ct=clnk , accessed 12 May 2009

make appropriate adolescent health services available and accessible; create a conducive physical environment; have the right drugs, supplies and equipment; provide information, education and communication.

In spite of the Return to School policy allowing girls to stay in school until delivery and to return soon thereafter, young girls continue to drop out because of pregnancy. Others decide to procure abortions so as to continue with their education. This policy needs to be strengthened and firmly implemented. First, parents/guardians, as well as the students, need to be educated on the existence and provisions of this policy. This in turn may encourage affected students and the parents/guardians to seek redress if denied a chance to return to school. Redress could be in the form of financial compensation and hefty fines for offending administrations and re-enrollment.

Other factors that should be revised while implementing this policy include:

- Improvement of socio-economic factors that influence "risky" adolescent behaviour and unwanted pregnancy. This includes provision of social services and job creation.

- Improving national security. Young women in Korogocho are faced with violence at some point in their lives. This negates the benefit of an education on contraceptive use or behaviour change and exposes the women to unwanted pregnancy and STDs/STIs.

4.2.2.2 Legalization of Abortion

Even with all the above in place, unwanted pregnancies (unplanned or mis-timed) will still occur. For example, in a paper presented at ECSAOGS 2003,[44] Prof. Steffan Bergstrom states that that there will always be unwanted pregnancies and the need for abortions – even in a country like Sweden with easy access to contraceptives and extensive sexual education, 20% of all pregnancies are terminated. As evidenced by the study, the legal environment restricting abortion forces the practice underground, thereby exposing young women to unsafe abortion. Giving these women a right to choice would go a long way in reducing maternal mortality and morbidity. It has been proven in other countries that access to safe abortion saves women's lives. "*Legal abortion in developed*

[44] Prof. Steffan Bergstrom 2003 *Safer illegal abortion – an ethical challenge*

countries is one of the safest procedures in contemporary practice, with case fatality rates of less than one death per 100,000 procedures."[45]

This is proven to be true in the case of developing countries such as South Africa. Since the passing of the Choice on Termination of Pregnancy Act (Act 92 of 1996)[46] (CTOP) in 1997, there has been a decrease in deaths from backstreet abortions, but the number of deaths following abortions is still quite high – 5% of maternal deaths following childbirth are abortion-related, and 57%of these are related to illegal abortions. A recent study in Soweto revealed the following: the rate of abortions for women older than 20 years decreased by 2% from 15.2% in 1999 to 13.2% in 2001. The rate for women aged between 16 and 20 years decreased from 21% to 14.9%, and the rate for women aged between 13 and 16 years decreased from 28% to 23%. In 2001, 27% of abortions were second-trimester.[47]

In other countries, partial legalisation often works against women seeking to procure an abortion. In Mexico, for instance, partial legalization of abortion, restricting it to cases of rape, health conditions or foetal defects within the first 12 weeks of pregnancy, has led to abuse by persons in authority. Human Rights Watch has reported[48] that in spite of these provisions, access to legal abortion is denied to many Mexican women through administrative hurdles and by negligence and obstruction by officials. One example cited is as follows:

> A social worker in Jalisco told Human Rights Watch: "We … had the case of an eleven- or twelve-year-old girl who had been raped by her brother. … She came here wanting to have an abortion, but we worked with her psychologically, and in the end she kept her baby. Her little child-sibling."

These prevailing attitudes also prevent several rape victims from reporting the crime. This situation is likely to be replicated in Kenya and hence avoided. Also, sexual violence in many cases is not overt in nature and may not be recognised as such by the victim. By hinging abortion to cases of rape or incest only may lock out several young women.

[45] D. Grimes et al: Unsafe abortion: the preventable pandemic.

[46] Available at: http://www.info.gov.za/acts/1996/a92-96.pdf , accessed 25 March 2009

[47] Dawes, A. (Ed.) (2003). The state of children in Gauteng. A report for the office of the Premier, Gauteng Provincial Governmen t. Pretoria: Child Youth and Family Development, Human Sciences Research Council. Page 82, 157, 161, 353

[48] *Ibid*.

Full legalization of abortion would open the door for modern procedures, such as MVA, which do not have as many side-effects as D&C or the more dangerous inducement procedure. Furthermore, with a favourable legal regime, abortion practitioners could be licensed to regulate the industry. This means that services such as pre- and post-abortion counselling could be provided to young women so as to ensure that they make informed decisions. Regulation would also improve sanitary conditions of procedure rooms, hence reducing illnesses such as post-abortion sepsis.

The existing draft Reproductive Health and Rights Bill should be thoroughly scrutinised and amended before being tabled.

4.3 Developing an Advocacy Strategy

To ensure success in implementing reproductive health and rights reform, an effective advocacy strategy must be developed. The following are brief guidelines for advocates in developing an advocacy strategy, adapted in part from *Women's Human Rights Step by Step*, Women Law & Development International and Human Rights Watch Women's Rights Project (1997).[49]

1. Define a clear position and desired outcome.

2. Articulate the strategy to be undertaken.

3. Evaluate selected activities for potential risks to constituents.

4. Build alliances and coalitions for support.

5. Develop a public education plan.

6. Undertake the chosen activity/activities

Successful publicity strategies such as that executed recently by the G10 should be learnt from. The Internet should also be used as a tool for disseminating information

[49] Available at: http://www.stopvaw.org/Developing_an_Advocacy_Strategy.html, accessed 12 May 2009

Conclusion

For the young women of Korogocho to enjoy satisfactory sexual and reproductive health they must be allowed to perform safe and legal abortions. Failure to do so continues to violate their reproductive and sexual rights, rights that are embodied in many human rights conventions. However, failure to recognise such rights will not reduce the number of abortions that occur in slums such as Korogocho. In other words, whether or not abortion is legalized, the women of Korogocho will continue to undergo abortion because of the reasons that have been described in this study. The various issues that cause unwanted pregnancy should be addressed and not merely discussed.

A girl was gang-raped by eight men while on her way home. She conceived and delivered a baby. Sometime later, the men who had raped her came to her home bearing gifts for the baby, such as nappies. They claimed they had come to visit 'their' baby and would be back. The girl smothered the child and dumped it.

Source: Research Respondent

Appendix
Questionnaire Sample

Questionnaire

"I would like to ask you a few questions about sexuality. I would like to understand what you think, say and do about certain kinds of behaviours related to reproductive health and sex. This interview will take about 45 minutes. The session will be tape-recorded and a transcript of the discussion will be made. By consenting to participate in the study, you are agreeing to the tape-recording of the session. Please be assured that at no time will I record any names or other identifying information. We will protect the information you give us as best we can. All tapes will be destroyed at the end of the study. I'm going to ask you some very personal questions that some people find difficult to answer. You may feel uncomfortable answering some of the questions. You are free to refuse to participate. You will not be penalised in any way if you decide not to participate. You can refuse to answer any question. You may stop the interview at any time and I will oblige. May I continue?"

- Yes
- No (Stop)

INTERVIEWER: You must sign below before proceeding. You signature certifies that the objectives and procedures for this study have been read to each participant. All of the participant's questions were answered and the participant has agreed to take part in the research.

Date	Signature of Interviewer

Section 1: Personal Profiles

1. Sex of respondent
   ☐ Male ☐ Female

2. How old are you?
   ☐ Less than 18 years
   ☐ 18 years – 22 years
   ☐ 23 years – 27 years

3. Do you have children?
   ☐ Yes ☐ No

4. How many children do you have?
   _____

5. How old are the children?
   ☐ Less than 5 years
   ☐ 5 years—10 years
   ☐ 10 years—14 years

6. Who takes care of the children?
   ☐ Mother (alone)
   ☐ Mother (with assistance of biological father)
   ☐ Parents/ grandparents
   ☐ Other_____

7. Are you currently enrolled in an educational institution?
   ☐ Yes ☐ No
   If NO, please move to Q. 9

8. If YES, which level?
   ☐ Primary
   ☐ Secondary
   ☐ College
   ☐ Other educational facility (polytechnics, short courses, apprenticeship, etc)

9. If NO, which level did you attain and why did you stop?

_____

_____

_____

10. Are you currently employed/ working for gain?

☐ Yes ☐ No

If No, what is your source of income?

_____

11. What is your marital status?

☐ Married/ Committed relationship

☐ Single

12. What religion are you?

☐ Christian- Protestant

☐ Christian-Roman Catholic

☐ Muslim

☐ None

☐ Other (please specify)

_____

_____

13. How often do you attend church/ mosque/ other?

☐ 4 or more times a month (committed)

☐ 1—4 times a month (regular)

☐ 1—6 times a year, religious holidays (rarely)

☐ Never

Section 2: Sex and Reproductive Health

Get any history of sexual violence.

Section A:

1. Have you ever engaged in sexual intercourse?
   ☐ Yes ☐ No
   If NO move to Q. 4

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 week
   ☐ Within this month
   ☐ 2—3 months ago
   ☐ 4 or more months ago

4. Do you know what contraceptives are (define and give examples if interviewee is unfamiliar with the term contraceptive)?
   ☐ Yes ☐ No
   If No, please move to section 3

5. Do you know where to obtain them?
   ☐ Yes ☐ No

6. Do you know any other young people who use contraceptives?
   ☐ Yes ☐ No

7. Do you think it is important to use contraceptives?
   ☐ Yes ☐ No

8. Why or why is it not important?
   _____
   _____

9. Do you use contraception?
   ☐ Yes ☐ No

10. If YES, what is your preferred method of contraception and why?
    ☐ Male Condom
    ☐ Emergency Contraceptive Pill (ECP)
    ☐ Birth Control Pills
    ☐ Female Condom
    ☐ Other (specify) _____
    Why?
    _____
    _____
    _____
    _____

11. Where did you learn about the contraceptives?
    ☐ School
    ☐ Friends
    ☐ Other (specify) _____

12. How often do you use contraceptives?
    _____
    _____
    _____

13. Where do you obtain the contraceptives?
    ☐ Local Duka/Supermarket
    ☐ Private Clinic
    ☐ Government Clinic
    ☐ Herbal clinic
    ☐ Vending machine
    ☐ Other (specify) _____

14. Did you use any form of contraception during your last sexual encounter?
    ☐ Yes ☐ No

15. If YES, which one?
    - ☐ Male Condom
    - ☐ Emergency Contraceptive Pill (ECP)
    - ☐ Birth Control Pills
    - ☐ Female condom
    - ☐ Other (specify) _____

16. If NO, why not?

    _____
    _____
    _____
    _____

17. Do you use contraceptives during every sexual encounter? Please explain

    _____
    _____
    _____
    _____

18. In your opinion, how can young people be encouraged to use family planning services or make them more willing to use contraception?

    _____
    _____
    _____
    _____

Section B: Quality of service at Reproductive Health Facilities

1. What do you think of the service you received at the facility?
    - ☐ Good
    - ☐ Average
    - ☐ Bad

2. Were you treated with respect? Please explain.
    - ☐ Yes ☐ No

    _____
    _____
    _____

3. Why did you choose this particular RH service?

_____
_____
_____
_____

4. Are there places you would not go for RH services?

_____
_____
_____
_____

5. What makes this RH service not so good for young people?

_____
_____
_____
_____

6. Do you think more girls or boys go for RH services? Please explain.
   ☐ Girls
   ☐ Boys

_____
_____

7. What would make RH services better?
   For Girls

_____
_____
_____
_____

   For Boys

_____
_____
_____
_____

Section 3: Termination of Pregnancy

Treat this section like you are bonding with a pal, as the interviewer you should only use these questions to lead you however you should let the person you are interviewing just talk and explain what happened etc… Please note any sexual violence.

1. Do you know if abortion is legal in Kenya?
   ☐ Yes ☐ No

2. If YES, when is it allowed?
   ☐ Yes ☐ No

3. Do you know anyone of your age who has had an unwanted pregnancy?
   ☐ Yes ☐ No

4. Do you know how she got pregnant?
   ☐ YES (please explain)

   _____

   _____

   ☐ No

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

   _____

   _____

6. Do you know how and where they did it?
   ☐ Yes ☐ No

7. If YES, please explain

   _____

   _____

   _____

8. Were they forced to take this action?
   ☐ Yes ☐ No

9. If YES, by who?
   - ☐ Parents/ Guardian
   - ☐ Father of the child
   - ☐ Religious Authorities
   - ☐ Other (specify) _____

   _____

   _____

10. Do you think what they did was right?
    ☐ Yes ☐ No

11. If YES, why?

    _____

    _____

    _____

12. If No, why?

    _____

    _____

    _____

13. Did they suffer any complications from the procedure?

    _____

    _____

    _____

14. Have you ever had an abortion?
    ☐ Yes ☐ No

15. If YES, why did you have one?

    _____

    _____

    _____

16. What month was the pregnancy?

    _____

    _____

    _____

17. (If after FIRST TRIMESTER) why did you take so long?

_____
_____
_____
_____

18. How much did it cost?

_____

19. Who or how did you get the money for the procedure?

_____
_____
_____
_____

20. How and where was the pregnancy terminated?

_____
_____
_____

21. Please describe the place that you procured the abortion. (State of bedding, if gloves were used, sanitary facilities, presence of pests)

_____
_____
_____

22. How clean was the room or procedure area:

☐ Good
☐ Average
☐ Bad
☐ Other_____
_____
_____

23. Was anaesthesia administered?

☐ Yes ☐ No

24. How were you treated by the staff at the clinic (if done in a clinic?)
    - ☐ Good
    - ☐ Average
    - ☐ Bad
    - ☐ Other_____
    _____
    _____

25. Medical Qualification of personnel:
    - ☐ Yes
    - ☐ None
    - ☐ Not aware

26. Pre-abortion counselling:
    ☐ Available ☐ Not available

27. Post abortion care:
    - ☐ Available
    - ☐ Not available

28. Did you need any follow-up/post abortion care?
    ☐ Yes ☐ No

29. If YES, why?
    _____
    _____
    _____
    _____

30. Have you or anyone you know, been arrested or harassed by the police?
    ☐ Yes ☐ No
    _____
    _____
    _____
    _____