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THE MANAGEMENT OF UNWANTED PREGNANCY AMONG WOMEN IN NAIROBI, KENYA

Chimaraoke Izugbara[1,2,3,4], Carolyne Egesa[1]

[1]African Population and Health Research Center, Nairobi, Kenya
[2]School of Public Health, University of Witwatersrand, Johannesburg, South Africa
[3]Department of Social Work, University of Gothenburg, Gothenburg, Sweden
[4]Department of Sociology & Anthropology, University of Uyo, Uyo, Nigeria

ABSTRACT. Qualitative data gathered from women in Nairobi, Kenya, were used to explore decision making in relation to unwanted pregnancy. Gender, livelihoods, morality, marital status, and male partners exerted extensively complex and multidimensional influence on women's management of their unintentional pregnancies. For instance, although gender norms were frequently invoked to justify terminating unwanted pregnancies, they also regularly provided strong motivations for carrying such pregnancies to term. Urgently needed are programs and policies that not only support women to avoid unwanted pregnancies, but also help them to respond safely and pragmatically to such pregnancies when they occur.

KEYWORDS. Qualitative studies, unplanned pregnancy, women, Kenya

INTRODUCTION

Worldwide, unwanted pregnancy persists as a major social and public health concern. A pregnancy is unwanted when it occurs at a time a woman did not want to be pregnant (Okonofua, Odimegwu, Ajabor, Daru, & Johnson, 1999). In sub-Saharan Africa, accidental pregnancies remain a particularly vexing public health issue: More than a quarter of the 40 million pregnancies that occur annually in this region are accidental (Islam, 2007). Although research on unwanted pregnancy in Africa continues to boom, much of it has addressed trends, risk factors, determinants, distribution, prevalence, and social, economic, emotional, health, and other implications of unwanted pregnancy (Cleland & Ali, 2006; Ikamari, Izugbara, & Ochako, 2013; Izugbara, Ochako, & Izugbara, 2011; Kaye, Mirembe, Bantebya, Johansson, & Ekstrom, 2006; Magadi, 2003, 2006; Marston & Cleland, 2003; Okonofua et al., 1999).

The drivers of women's choices when faced with an unwanted pregnancy are poorly studied. Research attention has resided primarily on women's motivation for seeking abortion (Bankole, Singh, & Haas, 1998; Font-Ribera, Pérez, Salvador, & Borrell, 2008; Jones, Darroch, & Henshaw, 2002; Jones, Finer, & Singh, 2010). Little research has interrogated the motivators of the range of different courses that women who suffer fortuitous pregnancies sometimes follow, including keeping the pregnancy, carrying the pregnancy to term but abandoning the baby or giving him/her away, and even infanticide. Robust scientific information on the drivers of the varied responses of women faced with unwanted pregnancy is critical to meeting their care, counseling, and other needs.

Building on a recent study of women's experiences of unintentional pregnancies in Nairobi, Kenya, we explore the drivers of women's choices when faced with accidental

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Address correspondence to Chimaraoke Izugbara, African Population and Health Research Center, Inc., APHRC Campus, 2nd Floor, Manga Close, Box 10787-00100, Nairobi, Kenya. E-mail: coizugbara@yahoo.com

pregnancies. We focus particularly on the meanings women ascribed to their unwanted pregnancies, their coping strategies, and the issues that drive their management of unwanted pregnancies.

CONTEXT

Kenya offers a particularly intriguing context for exploring women's fertility practices and matters related to their management of unwanted pregnancy. A developing country, with a population estimated at 39 million people (Kenya National Bureau of Statistics & ICF Macro, 2010), Kenya continues to experience an untiringly high prevalence of unwanted pregnancy. Although the country boasts one of the highest contraceptive prevalence rates in Africa (from 7% in the 1970s to 33% in 1993, 39% in 2003, and 46% in 2008–2009; Kenya National Bureau of Statistics & ICF Macro, 2003, 2010; Magadi, 2003), the proportion of its women reporting unwanted childbearing has remained among the highest in the region. In 2002–2003, nearly 50% of unmarried women aged 15 to 19 years old and 45% of married women reported their current pregnancies as unwanted or mistimed. In 2008–2009, this stood at 42% (Kenya National Bureau of Statistics & ICF Macro, 2003, 2010).

Unwanted pregnancy aggravates development issues for Kenya. It is a major barrier to achieving progress in sexual and reproductive health in the country. Each year, unwanted pregnancy causes several thousands of girls to drop out of school in Kenya (Integrated Regional Information Networks, 2008). It is also a leading cause of unsafe abortion and contributes immensely to high levels of maternal mortality and morbidity in the country (Alan Guttmacher Institute, 2000). A study on the magnitude of abortion complications in Kenya conducted in 2002 found that about 20,000 women annually sought medical care for abortion-related complications in Kenyan public sector hospitals alone (Gebreselassie, Gallo, Monyo, & Johnson, 2005). The treatment of abortion complications uses a large amount of scarce health system resources in Kenya. Incomplete abortions account for a large proportion of gynecological admissions in Kenya's public health facilities (Gebreselassie et al., 2005). The admissions are usually emergencies and require extended hospital stays, intensive care, and attendance by highly skilled health providers. Unwanted fertility is also a major contributor to Kenya's rapid population growth since 2005 and was a key factor in the recent revision of the country's projected population for 2050 from 54 million to 83 million people.

High levels of unwanted pregnancy in Kenya relate to poor access to, and use of, modern contraceptive products (African Population and Health Research Center [APHRC], 2009). The majority of poor Kenyan women and girls find family planning services and products unaffordable. Facilities that provide subsidized family planning products and services regularly experience both stock-outs and a dearth of qualified providers, and they are also mainly located in urban areas (Agwanda, Khasakhala, & Kimani, 2009). Stigma, fear of side effect, inadequate sexuality information, and cultural pressure inhibit the utilization of family planning services among women and girls in Kenya (Aloo-Obunga, 2003). Economic conditions in Kenya have plummeted since the 1980s, and women remain the worst hit by worsening livelihoods. More than half of Kenyans currently live below the poverty line. Chronic hunger, malnutrition, and deprivation characterize the lives of more than 10 million Kenyans, mainly women (Nyenze, 2002). Most of these women also suffer poor access to basic essentials and services, including family planning products, and are forced to survive by resorting to livelihoods and relationships that expose them to unwanted pregnancies and poor health outcomes (Njagi & Shilitsa, 2007).

METHOD AND MATERIALS

This study was conducted among women aged 15 to 49 years old in four communities—Korogocho, Viwandani, Jericho, and Harambee—in Nairobi. It builds on a

2009–2010 survey of unwanted pregnancy in these settlements. Korogocho and Viwandani are slum settlements characterized by overcrowding, insecurity, poor housing and sanitary conditions, and a lack of social basic amenities and infrastructure (APHRC, 2009; UN HABITAT, 2003). There is a high prevalence of risky sexual behaviors and poor sexual and reproductive health outcomes in the settlements. For instance, while Kenya's HIV prevalence stands at 7.4%, it averages 11.5% in these two settlements (Kyobutungi et al., 2009; National AIDS and STIs Control Program, 2007). Morbidity and mortality rates among residents of these settlements are, on the whole, high (Kyobutungi et al., 2008). On the other hand, Jericho and Harambee are nonslum settlements and enjoy better health and other indicators (APHRC, 2009).

Study Participants

In the survey, a total of 1,962 out of a targeted 2,000 women (1,000 per settlement type) were successfully interviewed, with 365 reporting at least one episode of unwanted pregnancy. The survey component used a two-stage sampling design to recruit participants. The initial stage involved a random sampling of households from the four settlements. The APHRC operates the Nairobi Urban Health and Demographic Surveillance System (NUHDSS) in these settlements. The sample of households was drawn from APHRC's sampling frame of NUHDSS households. The second stage involved a simple random selection of 1 eligible woman in each of the sampled households. Respondents for the qualitative component were 80 randomly selected women who participated in the larger survey and self-identified as having experienced at least one episode of unwanted pregnancy. They also had to consent to be interviewed further regarding those pregnancies. Of the 365 women who reported unwanted pregnancies in the survey, 313 (86%) agreed to be further interviewed about them. The 80 participants for the qualitative study were selected from these 313 women. We first stratified the sample on the basis of settlement type—slum and nonslum. From each settlement type, 40 participants were recruited using the systematic random sampling technique. Although random selection is not usually required for qualitative interviewing and could, in fact, be counterproductive, we opted for it to remove the selection of participants from our hands. We also sought to achieve maximum variation sampling, which ensures representation of diverse dimensions of the issue being explored. The sample size of 80 women was arbitrary and motivated largely by a concern with analytical expediency.

The Ethical Committee of the Kenya Medical Research Institute approved the study. Verbal informed consent was further obtained from all interviewees for their participation and for the audio-recording of their responses. We did not obtain written informed consent from the respondents. This prerequisite was waived for the investigators, as a signed document could link the respondents to the study possibly resulting in a breach of confidentiality (Sieber & Levine, 2004). Parents or guardians gave additional approval for the interviewing of their unmarried wards aged younger than 18 years old. In Kenya, married persons and those aged 18 years and older are considered adults in their own right. They often do not need further parental permission to grant research interviews. When respondents' homes were not ideal for the interviews, fieldworkers agreed on an alternative place free from the attentive eyes, threat of sanctions, and pressure of nonparticipants. Interview sessions lasted an average of 45 min and were all audio-recorded. The respondents were also informed that they might be recontacted to clarify their responses. Pseudonyms have been used in the article to shield the identity of the respondents.

Data Collection

In total, 80 in-depth individual interviews were conducted during a 4-month period. Interview questions sought participants' views regarding their unwanted pregnancies, what it meant for them, how they managed it, and why they resorted to particular coping strategies. The study instruments drew largely from

earlier studies and were also reviewed and approved by an international team of abortion, unwanted pregnancy, and fertility behavior researchers. The team of experts thoroughly scrutinized the instruments for relevance, content, and clarity and approved the final version used in the study. Two language experts translated the tool into Swahili (Kenya's national language). A third translator, working independently, reviewed the Swahili version against the original English tool. All three translators and the study team agreed on the final Swahili version of the tool. All interviews began by seeking respondents' consent to be interviewed and ended by asking them if the interviewer had missed anything about (their) unwanted pregnancies. All interviews were conducted using an in-depth individual qualitative interviewing guide, administered in Swahili by four trained female fieldworkers experienced in qualitative interviewing. The fieldworkers, mostly university graduates or students, were employees of APHRC's NUHDSS at the time of the study. The training, conducted by expert qualitative researchers, introduced the fieldworkers to the aims of the study, familiarized them with the study guide, and exposed them to guided dialogue techniques and critical tips for qualitative interviewing.

Data Analyses

Transcribed interviews form the study data. Three professional translators were involved in the translation of the interviews. Initially, one translator transcribed all the taped interviews from Swahili into English. The transcripts were then carefully compared to the taped interviews by two other translators. All three translators agreed on the final version of the transcripts. Using the fishbowl sampling method, 10% ($n = 8$) of the transcribed interviews were selected for discussion with the respondents who granted them. At first, the interview data were concurrently but independently coded by the lead author and a professional qualitative data coder, relying on Creswell's (1997) version of Strauss and Corbin's (1990) grounded theory. Later, the authors and coder met to appraise the coding outcomes, ensure intercoder concordance, and agree on a codebook that reflected the thematic groupings of the interview questions and the key issues emerging from the data. Based on the jointly developed codebook, transcribed interviews were then finally coded with Nvivo. A qualitative inductive approach involving thematic assessment of the narratives was adopted to understand the data. Higgins, Hirsch, and Trussell (2008) and Thomas (2003) have suggested that this approach promotes the detection of overriding themes in qualitative data as well as the understanding of the meanings and messages of themes through the continual investigation of narrative data for categories, linkages, and properties. In many instances, word-for-word quotations are used to show responses on significant issues and themes.

RESULTS

Study Participants

Participants ranged in age from 16 years to 49 years old and had a median age of 36 years. The majority had primary-level education. There were also those without formal education or with secondary education and above. In total, the mean years of completed formal schooling for the respondents averaged 8 years. Participants were mainly married, cohabitating, or widowed. Some were also divorced or single women. In terms of livelihoods, respondents were mainly full-time housewives, unemployed persons, and students. Several self-reported as petty traders and small-scale entrepreneurs. Formal sector employees were a minority in the sample. Kikuyu, Luo, Luhya, and Kamba were the commonly mentioned ethnicities in the sample. Borana, Kisii, Somali, Gare, and Kuria were the others. Christians comprised 89% of the sample and Muslims comprised 11%. Slum-based respondents tended to have larger families, lower educational attainment, and lower incomes compared with their nonslum counterparts. More slum-based women were also unemployed or full-time housewives. On the other hand, nonslum women were more

likely to be in formal employment, own a business, and be currently married.

Beliefs About Unwanted Pregnancy

Unwanted pregnancy was reportedly common in the communities we studied. In addition to admissions of personally experiencing it, the women knew at least one woman or girl in their community who had experienced unwanted pregnancy: "It is common here for women to become pregnant when they don't want to"; "It is common among all categories of women in this community, we always get pregnant when we don't want it"; "It is common . . . I can say that many of my friends in this community have become pregnant without wanting to be . . . there are really many incidents; some of my friends tell me they were not expecting that pregnancy." Different respondents affirmed. Respondents' unwanted pregnancy occurred at different points in their lives: Some were single, others were married, and yet others were divorced and widowed. Some were adolescents, some were adults, some already had children, and some had not started childbearing when their pregnancies occurred.

Single, married, divorced, widowed, and indeed all women of reproductive age were said to be at risk for experiencing unwanted pregnancies. Martha, a 30-year-old respondent had experienced two episodes of unwanted pregnancies as a married woman. One of them occurred a year after the birth of her second child. The other occurred after the birth of her fourth child when she no longer wanted another child. Martha also told us that her niece who resides with her also recently aborted at age 15. Twenty-seven-year-old Linnet experienced her unwanted pregnancy soon after she got a job as a house help. The pregnancy had the potential to stop her from continuing with the work, which she then desperately needed. In the case of 35-year-old Akoth, her unwanted pregnancy occurred when she was jobless and could barely feed her two children. She did not want a third child as she was already struggling with caring and supporting the two she already had. On the other hand, 20-year-old Viola experienced her first unwanted pregnancy as a single girl and student.

Responding women reported being afraid, angry, and distraught when they discovered that they had become pregnant inadvertently: "When I found out, I was so scared, I nearly killed myself, I did not know where to begin," admitted 25-year-old Maria. The data we collected suggested that responding women regularly blamed themselves for their unwanted pregnancies. Twenty-eight-year-old Rachel became pregnant a few months after her husband died. She said: "When I discovered I was pregnant, I really felt ashamed of myself, I was to blame. I should have been more careful." In Rachel's ethnic culture, widows mourn their husbands for several months before resuming sexual activity. Rachel notes: "I just thought I had been loose and irresponsible. If people found out, they would say, 'That one is promiscuous, she did not even wait for her husband to be buried before going with other men."' Similarly, Bibi (aged 24 years) reported that her unwanted pregnancy occurred when she was in secondary school. The experience left her feeling afraid, wayward, and licentious. Unwanted pregnancies also exposed the women to abandonment and rejection by male partners, families, and friends. One woman told us that her parents chased her away when she became pregnant. Responding women tended to keep their unwanted pregnancy secret and shared only with trusted friends and associates and sought their advice. For instance, when we asked Bibi who she shared news of her unwanted pregnancy with, she said: "Nobody really; when I told the man responsible and he rebuffed me, I decided to deal with it myself."

Although married women experienced unwanted pregnancy, respondents' shared sentiment was that unmarried girls were at higher risk for it. Single women also reportedly experienced more difficulties dealing with unwanted pregnancy. Julie, a 40-year-old mother, noted that while married, women may accept any pregnancy that comes to them "even if they are not happy with it; young girls may not have that option." Similarly, 32-year-old Lakuya recalled that when she accidentally became pregnant,

a close friend advised her: "Why do you have to worry that much, after all, you are married and you are married to give birth to children? Just have this one and be more cautious next time." Unmarried participants also poignantly articulated the view that they have more difficulties dealing with unwanted pregnancy. Sarah (aged 22 years) did not understand why unwanted pregnancy would be an issue for married women: "If I was married when I became pregnant accidentally, I would have kept it. But I was not." She further reported, "Married people can walk into any chemist or clinic and ask for contraceptives. They can also ask their husband to buy it for them. Even if you get pregnant, you can still keep it because you are already married." In Sarah's view, some of the difficulties of unmarried girls include that they may not easily ask their boyfriends to use condoms as it might betray them as sexually wayward, untrustworthy, or too knowledgeable. She added: "Young girls may not even know where to get contraceptives and may feel shy to ask for those from providers. They may be in school and not ready to have children. This is why I said that it is more complicated for them."

Unwanted Pregnancy: Risks and Benefits

Different circumstances surrounded the unwanted pregnancies of participating women. Generally, however, women did not consider pregnancies to be unwanted because they simply occurred when women became pregnant without wanting to. Rather, pregnancies were considered unwanted largely because they had occurred in contexts that did not reinforce traditional notions of consummate motherhood and competent womanhood and of women as nurturers and wives; they were incongruous with traditional beliefs about "proper" procreation; and they revealed women's use of their sexuality in culturally unacceptable ways. The women generally defined and described proper motherhood and womanhood in terms of the ability to care for and nurture children and be a homemaker and wife. They also tended to consider pregnancy and procreation occurring outside the institution of marriage as reprehensible. As such, participating women described as unwanted their pregnancies that occurred when they were not married, were expected to be mourning their husbands, or were ill and unable to cater for children, among others.

For instance, 24-year-old Jeru said her pregnancy was unwanted because it occurred in a nonmarital, nonwifehood context. In the same vein, 30-year-old Maite explained the unwantedness of her pregnancy against the background of her unmarried status. She could have kept and fended for the baby, as she told us. She was primarily concerned that the pregnancy challenged her respectability as a woman. Norms of gender do not permit her to experiment with sex outside of marriage. A tolerable pregnancy, she told us, should occur within a marital union. Maite insisted: "If I had kept the baby, people would call me a prostitute."

Similarly, 38-year-old married Jula explained her unwanted pregnancies thusly: "I just wanted to be the best for the children I had already. The pregnancy came when I got a job and I said to myself, 'Now I have a job, I don't want to give birth and leave the child to a nanny. I wanted the child to grow up knowing that I am the mother."' Essentially, Jula associated good and proper womanhood and motherhood with the capacity to nurture and care for one's children. In deciding that she did not want a particular pregnancy because it had occurred at a time during which she was not prepared to provide "adequate" motherly care, Jula underscored the salience of beliefs that frame capable motherhood in terms of nurturing, wifehood, and homemaking. In another interesting example, 45-year-old Minyo told us that she did not want her pregnancy because it occurred when her daughter was also pregnant. In her culture, only indiscreet and undignified women continue to bear children when their daughters have also started childbearing. She did not want to be an irresponsible *nyanya* (grandmother).

Women associated unwanted pregnancy with both risk and benefits, which were largely framed in gendered terms. For some responding women, unwanted pregnancy confirmed their fertility, fecundity, and potential for motherhood; it enabled them to establish,

realize, and affirm their procreative potential: "Although I was scared and worried, it made me know I was truly a woman and could bear children. You know there are many girls who cannot tell whether they are fertile or not . . . only I still did not want it," asserted 22-year-old Melissa. There were also women who reported that they got married because of their accidental pregnancies. Unintentional pregnancies also presented women with both a wake-up call and the moment and opportunity to reassess their relationships and reflect on their life situations. Winny thus told us: "It was scary for me, but it taught me a lot about my boyfriend." This was also the case with 27-year-old Nyagara who developed a critical perspective about her boyfriend following her unplanned pregnancy. When she told him about it, he reacted violently and beat her up. The incident marked a turning point in her relationship with him. She realized that he was not her man and was not worth her time. The reverse was, however, the case for Njoki whose boyfriend, learning that she was pregnant, asked her not to abort it and proceeded with marriage arrangements. For 39-year-old Marian, an unwanted pregnancy forced her to open a private business after having lost the support of her family. Her business has since grown and she currently employs people to work for her. She said, "If I did not get pregnant and become abandoned by my family, I [would] not have gone into business. Everybody abandoned me, so I had to fend for myself. I thank God I had some money which enabled me to establish a business and become what I am today."

Participating women also associated unwanted pregnancy with risks. Unsafe abortion, poor or ill health, hardship, neglect, abandonment, and marital problems were some of the reported risks for accidental pregnancy. They also reportedly had the potential to reveal women's use of their sexuality in "improper" ways. Several of the women thus felt that their unwanted pregnancies indicated their waywardness, sexual experience, and indecorum. Unwanted pregnancy reportedly worsened livelihoods for some of the respondents. Reports of losing jobs, family support, social networks, and opportunities because of unwanted pregnancy were common among the women. Carrying an unwanted pregnancy to term or procuring a termination also cost the women. Mary, aged 25 years, told us that she had two children when she became pregnant again unintentionally. She carried the third pregnancy to term, but told us: "I struggle every day to support them. I knew three children will be too much for me; that is why I did not want the third child." The women who were studied managed their unwanted pregnancies in two primary ways: carrying the pregnancy to term or terminating it. Other frequently mentioned ways women managed unintentional pregnancies were killing, giving away, or abandoning the baby after delivery. Some women and girls also reportedly commit suicide because of unplanned pregnancy.

Influences on the Management of Unwanted Pregnancy

In the study, several factors influenced women's decision making in the context of unintentional pregnancy. These factors included gender, livelihoods, morality, law, marital status, and male partners. Interestingly, the implications of these factors for the way women managed their accidental pregnancies were complex and resulted in a variety of coping strategies among them. Livelihoods were a commonly mentioned influence on the way women managed their unwanted pregnancies. However, the influence of livelihoods on the women was quite intricate. In some instances, poverty drove women to keep an unwanted pregnancy, while in others, it motivated them to seek abortion. Being well-off also produced varied unwanted pregnancy management strategies among the women we studied. Driving home this point, 40-year-old Jumani says: "Before deciding what to do with an unplanned pregnancy, you ask yourself: 'What will having the baby do to me?' If your family is already large and you are struggling or if you are in school, it means having the baby may hurt you."

Generally speaking, however, unintentional pregnancies that women thought would

improve their livelihoods were often kept. Those considered capable of worsening women's conditions tended to be aborted or carried to term for the babies to be abandoned, killed, or fostered out. Mary, a 20-year-old woman, kept her unplanned pregnancy because she saw it as an escape route from poverty. She said: "I was not sure of him because he never said anything about marriage, but when I got pregnant and he said it was fine with him and he was willing to marry me, I told myself, I will at least have someone to take care of me." On the other hand, there was also Nduku who used her accidental pregnancy to influence the man responsible to open a business for her. He was a married man and preferred her to abort the pregnancy; he even brought drugs for her to use for the abortion, but she refused. She saw the pregnancy as an opportunity to get something of value from the man and promised to keep the pregnancy secret from his wife: "I could have aborted the pregnancy, because it was accidental; but for me, it was an opportunity. . . . The man had money, so terminating the pregnancy would be to blow my luck away. So I decided to keep it because it was better for me. I got him to open a shop for me."

Unwanted pregnancies that were viewed as potentially harmful to women's future and current livelihoods were viewed as better terminated or carried to term and the child ultimately killed, given up for adoption, or abandoned. Respondents told us that women who already had large families or who were struggling to fend for their children could complicate their lives by keeping an unintentional pregnancy. Such pregnancies could worsen women's livelihoods and cause them more hardship. Ma Silva (40-years-old) was already having difficulties coping with five children as a widow. When she found out she was pregnant again, she was unhappy. Though Ma Silva gave birth to the baby, she gave her up for adoption. On the other hand, some respondents reported considering the implications of their unintentional pregnancies for their future livelihoods, schooling, continued support from family and partner, future life opportunities, and potential to, among other things, find a good husband. Maria was 19 years old when she became accidently pregnant. She was still a student and was supported by her parents. She told us: "I chose to abort because I was concerned about my future. If I had that baby, my parents would chase me away and I [would] drop out of school."

On the other hand, there were women who reported that they kept their unwanted pregnancies because of poor livelihoods. Ordinarily, they would have sought termination, but they did not have the resources. Mary was one of such women. She seriously wanted an abortion, but could not afford it. Her friend had nearly died the previous year from complications from an unsafe abortion. Mary preferred the services of a qualified provider, but she did not have the resources. Friends even told her of drugs and concoctions to drink, but she was too afraid to try them. She carried the pregnancy to term, gave birth to the baby, and put her up for adoption. In other instances, poverty also caused women to manage their pregnancies through unsafe abortion services. However, there were also women who reported that they procured abortion services because they had money to do so during the period: "It happened that I had some money then; I went to a nurse friend of mine who told me where to go. It was simple and fast. I was lucky that I had money that time."

Men responsible for unplanned pregnancies also exerted considerable influence on how women managed the pregnancies. The influence of male partners on the management of unintentional pregnancies was also both complex and multidirectional. Generally speaking, it mattered a great deal for women whether the pregnancy was for a man they loved, a poor or rich man, a married or single man, or a man related to them, among others. As one woman told us, "What you do with your pregnancy also sometimes depends on the man responsible for it . . . for instance, I cannot keep a pregnancy from rape." In some instances, husbands reportedly did not want more children and expected wives to know what to do. Josephine, a mother of five, exemplified this situation. Her husband did not want another child and had

clearly told her to prevent future pregnancies. When she became pregnant, she aborted without her husband's knowledge. As she said, "My husband had already made it clear that he did not want another pregnancy, so I knew it would be a waste of time trying to convince him to accept."

But there were also instances where the men responsible for the pregnancies directly requested women to keep them or paid for them to be terminated. Louisa told us she carried her pregnancy to term because the man responsible told to her to do so. When she got pregnant and asked the man (who was already married) for money to terminate it, the man told her to have the baby and promised to support her and the baby. According to Louisa, the man has lived up to his promises. The complex influence of male partners on the management of unwanted pregnancies was further attested to by 30-year-old Julie who carried her unwanted pregnancy to term. The pregnancy was with a man she loved but who mistreated her. Julie told us she kept the pregnancy because she wanted to keep the memory of the romance alive, though she did not want to continue her relationship with the man.

Gender norms also exerted considerable influence on the management of unwanted pregnancy. Idealized notions of femaleness and women's roles featured constantly in women's explanations regarding their responses to their unwanted pregnancies. Yet, like the other factors discussed, gender produced varied management tactics for unwanted pregnancy among the women. For some women, norms of gender propelled them into seeking termination for their unwanted pregnancies. But for others, gender norms motivated them to carry their unwanted pregnancy to term. The women we studied tended to have clear notions of what constituted socially sanctioned pregnancies. To qualify as appropriate, a pregnancy needed to reinforce conventional notions of motherhood and competent womanhood; occur in contexts that were compatible with local beliefs about "proper" procreation; and not reveal women's use of their sexuality in culturally disagreeable ways: "Pregnancy does not qualify one to be a mother," asserted 34-year-old Sheila. She further noted: "We can all get pregnant . . . but that does not mean that you are ready to be a mother. It is only good to get pregnant when one is really ready." When asked what qualified women as good mothers and wives, Sheila noted: "You need to know how to take care of your babies and husband and keep a home. I was not sure I was ready for that . . . I was scared." Ma Rosa, a 41-year-old woman, also maintained: "It is not just being pregnant . . . it is also about how ready you are at that time for motherhood."

Myra's first pregnancy was unwanted and therefore was terminated. In our discussions with her, she remarked: "I did not want to keep that pregnancy. I was 15 then, he said he was ready to marry me . . . but I was scared and not sure I was mature enough for it. I did not know anything about being a mother or wife." Sheila noted that she was scared that she would not make a good mother and wife if she gave birth then. Likewise, Chiro admitted that she sought abortion because "having a child at that time would just make the whole world think that I am a spoilt girl." When asked about the difference between the pregnancy she wanted and kept and the one she had not wanted and had not kept, Chiro's response was instructive and strongly invoked the gender norm that responsible women explore their sexuality and have children within marital contexts: "The main difference is that if I kept it, people would look at me like as a prostitute. But the other ones occurred when I was already married so nobody could call me an unscrupulous woman."

There were also respondents who admitted keeping their unwanted pregnancies because they were good mothers and therefore compassionate. To them, although unwanted pregnancy can be alarming and greatly distressing, good women do not abort: "I don't have the heart to abort or give my baby to another woman," one woman said. "I am a woman, women have a soft heart. I contemplated abortion, but I could just not do it. I am not callous, I am a woman," offered another. Morality, social network, law, stigma, and health issues

were other critical influences on women's management of unwanted pregnancies. The women spoke about how they decided to carry their pregnancies to term because of the illegality of abortion, their fear of abortion, lack of knowledge of where to obtain a safe abortion, and failure of their unwanted pregnancies to abort after different attempts, among other reasons. There were also women who said they kept their unwanted pregnancies because of their religious beliefs or because their peers, family, and community knew about the pregnancy and would stigmatize them if they aborted. Twenty-six-year-old Pat told us: "When I got pregnant, I was so scared. But before I knew it, the rumor had spread, so there was nothing I could do. I just had to keep the pregnancy." In other instances, the pressure to secure an abortion came from peers, family, or community. One respondent told us she wanted to keep her accidental pregnancy but decided against it due to pressure from friends and family.

CONCLUSION

Women's responses when faced with unwanted pregnancy are divergent and the issues that influence these responses are complex. This study investigated influences on women's choices when faced with unwanted pregnancy. It therefore adds to the debate on possible drivers of women's coping practices with unwanted pregnancy and provides evidence regarding the complicated character of women's choices related to unwanted pregnancy. Previous research on women's responses to unwanted pregnancy has focused largely on abortion, which has generally been explained in terms of poverty and livelihood (Bankole et al., 1998; Font-Ribera et al., 2008; Sihvo, Bajos, Ducot, & Kaminski, 2003). In Bankole et al. (1998), for instance, livelihood-related matters were considered as major motivations to seek abortion. Font-Ribera et al. (2008) also contended that women's resort to abortion in the face of unwanted pregnancy can be understood largely in terms of poverty. Relying on data from women in Barcelona, Spain, they showed that the lower the socioeconomic position, the higher the proportion of women who choose an induced abortion in the context of an unintended pregnancy. These studies did not probe the determinants of the other courses, including carrying pregnancies to term, to which women dealing with unplanned pregnancy sometimes also resorted.

Findings from the current study corroborate widely held views that unplanned pregnancy is a problem that women of different socioeconomic and demographic characteristics suffer. The women we studied acknowledged being deeply troubled and distressed by experiencing unwanted pregnancy. Story (1999, p. 1) argues that the panic and anxiety that women face when confronted with an unwanted pregnancy "are not just individual attributes but a reflection of wider social views about women's responsibility for sexuality and reproduction." Because of shame, stigma, and fear, only a few of the women we studied told their families, partners, and friends of their plight. Most of them kept their experiences secret, which potentially intensified their isolation and depression (Story, 1999).

In the study, pregnancies were not merely considered unwanted because they occurred when women became pregnant without wanting to be pregnant. Rather, they were unwanted largely because they had occurred in contexts that did not reinforce traditional notions of consummate motherhood and competent womanhood, were incongruous with traditional beliefs about "proper" procreation, and revealed women's use of their sexuality in culturally unacceptable ways. Izugbara et al. (2011) argued that unwanted pregnancy had a diversity of significance and implications for women and that women's tendency to invoke gender scripts to describe unwanted pregnancy make it and its consequences, including unsafe abortion, widespread. Responding women expressed a high level of awareness of the risks and benefits of unwanted pregnancy. These were, however, also largely framed in gendered terms. For some of the women, unwanted pregnancy woke them up to realities of their relationships

and confirmed their fertility, fecundity, and potential for motherhood, which enabled them to establish, realize, and affirm their procreative potential. For others, it highlighted their deployment of sexuality in culturally unacceptable ways and exposed them to risks for unsafe abortion, poor or ill health, hardship, neglect, abandonment, and marital problems. Geronimus (2003), among others, has called attention to the role of fertility as a gendered phenomenon. She argues that although women may use their fertility to accomplish different roles and obligations in ways that fit their socioeconomic realities, it is also a major source of risk for poor health among women.

The evidence generated in this study indicates that women's management of unintentional pregnancies was motivated by many factors, including gender, livelihood, morality, law, marital status, and male partners. The implications of these factors for the management of accidental pregnancies were, however, complex and multifaceted and resulted in different responses among the women. For instance, being poor, just like being well-off, induced women to abort in one situation, and in the other, it made them keep their unwanted pregnancies. Male partners also exerted a multidirectional influence on the management of unintentional pregnancies. They drove women to both keep and abort their unwanted pregnancies. Gender, too, produced varied responses toward unwanted pregnancy. Norms of gender propelled some women to terminate their unwanted pregnancies but were also similarly a reason that some women did not abort theirs.

The multidimensional implications of these factors for women's choices in the context of unwanted pregnancy are critical for both research and practice. Despite acknowledgements that complexity surrounds women's decisions in the context of unwanted pregnancy (Bankole et al., 1998), existing literature continues to paint a simplistic picture of the role of livelihoods in women's choices related to unintentional pregnancy. For instance, poor livelihood continues to be viewed as the key reason that women faced with unwanted pregnancy seek abortion (Jones et al., 2002, 2010; Korejo, Noorani, & Bhutta, 2003; Rasch et al., 2008). The same uncomplicated picture pervades the literature on the role of morality, law, and marital status on women's management of accidental pregnancies. On the other hand, the influence of critical factors such as gender norms and male partners on women's decisions regarding their unplanned pregnancies has hardly been interrogated.

The uncomplicated portrayal of the implications of livelihood, marital status, and morality for the management of unwanted pregnancy and the lack of research on the role of gender and male partners in women's responses to unwanted pregnancy have hindered in-depth understanding and critical appreciation of the complexities surrounding women's responses to unwanted pregnancy. Our data suggest that critical social and situational issues interact in complicated ways to shape women's choices in the context of unwanted pregnancy. This is important and suggests that more research is needed on the complex interaction between women's responses to unwanted pregnancy and social and contextual factors.

Our findings also raise urgent policy and programmatic issues. In Kenya currently, several women lack access to quality sexual and reproductive health information, effective family planning services, and comprehensive abortion care. Programs and policies that enlarge women's access to quality contraception, sexuality information, and abortion and postabortion care are needed to reduce unintended pregnancies and support women to manage such pregnancies more safely when they occur. Also important is the need for services that are responsive to the sociocultural and livelihood contexts within which women faced with unwanted pregnancy make decisions about their situations.

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