

Lived experiences and pathways to abortion in Kilifi County, Kenya



African Population and Health Research Center



Rutgers

Table of contents

List of tables	ii
List of graphics	iii
List of acronyms	iii
Acknowledgement	iv
Research team	v
Foreword	vi
Executive summary	vii
Introduction	1
Methods	3
Findings	9
I. Factors contributing to unintended pregnancies	9
II. Decision-making for abortion: a matter of choosing the lesser evil?	18
III. Care / help-seeking pathways to abortion	25
IV. Post-abortion care: When things get out of control	34
Discussion	43
Conclusion and recommendations	48
References	50

List of tables

Table 1: Socio-demographic characteristics of adolescent girls and young women interviewed	6
Table 2: Key informants interviewed	7
Table 3: Reasons for abortion	24
Table 4: Methods known versus methods used and sources of information	30
Table 5: Multiple and mixed abortion methods used by some of the participants	32

List of graphics

Figure 1: Nature of the sexual relation at the time of pregnancy	16
Figure 2: Factors driving unintended pregnancy among participants	17

List of acronyms

APHRC	African Population and Health Research Center
AYSRH	Adolescent and Youth Sexual Reproductive Health
CBO	Community Based Organization
CHV	Community Health Volunteer
ESRC	Ethics and Scientific Review Committee
HIV	Human Immunodeficiency Virus
KDHS	Kenya Demographics and Health Survey
MA	Medical Abortion
MoH	Ministry of Health
MP	Menstrual Period
MVA	Manual Vacuum Aspirator
NACOSTI	National Commission for Science, Technology and Innovation
NGO	Non-Governmental Organization
PAC	Post-Abortion Care
PDRH	Population Dynamics Sexual and Reproductive Health
PPE	Personal Protective Equipment
RHNK	Reproductive Health Network Kenya
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health Rights
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
VCAT	Values Clarification and Attitude Transformation

Acknowledgement

This ethnographic study was conducted by the African Population and Health Research Center, Rutgers and the Kilifi County Department of Health, with funding from the Dutch Postcode Lottery as part of the She Makes Her Safe Choice Program. The study team wishes to thank the Kilifi administrative authorities for their continued support from the inception of the study to its dissemination.

We also thank Dr. Caroline Kabiru, Head of the Population Dynamics Sexual and Reproductive Health Unit, for her support in implementing the study and for reviewing the final report and providing insightful feedback. We are grateful to Dr. Stephen Kaliti and Dr James Gitonga for reviewing the protocol and the report, and for supporting the study team throughout the process. We thank the Safe Choice Programme partners for their support during data collection and validation of the study findings. A special thanks to Nelly Munyasia, Executive Director of Reproductive Health Network Kenya (RHNK), and Dr John Nyamu, who consistently advised the research team throughout the implementation period. We also thank Michelle Mbutia from APHRC Policy Engagement and Communication department for reviewing the report, and her consistent support in the dissemination of the findings. We appreciate the support of attendees in the validation meeting, including civil society organizations, researchers, ministry of health representatives, county government representatives, and representatives from organizations working in the field of sexual and reproductive health.

We are eternally grateful to the girls and young women who participated in the study, as well as their relatives, healthcare providers, and the policymakers from Kilifi County, Kilifi North, and Kaloleni sub-counties. Moreover, we thank the girls and young women who showed our team hospitality and welcomed them in their homes and in their private lives and spaces. You have shared with the researchers a most intimate and difficult phase in your lives. These are stories that need to be told in order to shed light on the difficulties many girls and young women experience in their lifetimes, but so often remain hidden. Sharing these stories will help to improve the experiences for other girls and women in the future. We are deeply impressed by your courage and thank you for your trust. Your stories rightfully provoke anger, indignation, and sadness. We hope that this study will spark action by all relevant stakeholders, and to this end the report concludes with strong and urgent recommendations.

Finally, we are grateful to and deeply impressed by the talented and dedicated team of young researchers who spent six months in the field conducting this ethnographic study and thereafter joined for the analysis and write-up: Anne Achieng, Jane Shirima, Mercy Kadzo, and Shilla Dama.

Research team

APHRC:

Ramatou Ouedraogo
Grace Kimemia
Shelmith Wanjiru
Anne Achieng
Shilla Dama
Mercy Kadzo
Jane Shirima

Rutgers:

Jonna Both
Camilo Antillon

Kilifi County Department of Health:

Kenneth B. Miriti

Report Citation:

APHRC, Rutgers, and the Kilifi County Department of Health (2021). Lived experiences and pathways to abortion in Kilifi County, Kenya. APHRC, Nairobi, Kenya.

Foreword

In Kilifi County, adolescents and young people (10-24 years) comprise the majority (65%) of the population. Children below the age of 15 represent 46% of the population, whereas those aged 15 to 24 years constitute 19%. To capitalize on this demographic dividend and harness the potential of this young population, the Kilifi County Government has continued to invest in programs and policies that address the plight of young people. However, several challenges remain that must be addressed to guarantee their health and wellbeing and maximize outcomes from the County's ongoing investments.

The County has remarkably poor adolescent and young people's sexual reproductive health indicators. This is reflected in the high HIV infection rates, the high pregnancy rates among adolescents, and the unsafe abortions that have been reported in the past few years. Consequently, the education of young girls is disrupted, their health threatened, and their economic opportunities diminished, further exacerbating their future vulnerability. The emergence and persistence of the COVID-19 pandemic has only aggravated the situation in the County.

Though teenage pregnancy rates have declined substantially, from 35% in 2018 to 13.4% in 2021, challenges surrounding the sexual reproductive health of adolescent girls and young women persist. While the County Department of Health routinely collects data on post-abortion care within the local health facilities, not much is known about unsafe abortions, and little evidence exists on the drivers of unsafe abortion, its effects on health, and its socioeconomic impacts. A study that explores the lived experiences, the determinants, the pathways to abortions, and its effects on health and socioeconomic circumstances is crucial in a county where 13.4 % of the women receiving care in antenatal clinics are younger than 16.

Kilifi County Government prioritizes young people's health as key to achieving sustainable economic prosperity, and it is in this regard that the county has deployed a multisector approach towards adolescent and youth programs. The ethnographic study by APHRC and Rutgers in Kilifi County has opened avenues for more conversation into the causes and effects of unsafe abortion among girls and young women.



Dr. David Mulewa
County Director of Health
Kilifi County

Executive Summary

According to the Kenya Demographic and Health Survey of 2014, over 35% of the total pregnancies reported in the country are unintended. Nearly half of these pregnancies end in an induced abortion, and worse still, a considerable number of them result in mild to severe complications, which often lead to death and/or disability. While there is increasing research on the drivers of abortion, few studies have looked into how access to information, cultural and socioeconomic factors, sexual and gender-based violence (SGBV) as well as the different actors involved drive unintended pregnancies and influence the decision-making process and subsequent management of abortion complications. In order to contribute to drastically reducing maternal morbidity and mortality as a consequence of unsafe abortion, this research was envisaged by Rutgers and APHRC as part of the She Makes Her Safe Choice Program¹, to address some of the remaining knowledge gaps around the drivers of unsafe abortion in Kenya. We carried out a six-month ethnographic study within two sub-counties in Kilifi, in rural and urban settings. We engaged in participant observations and conducted informal and in-depth interviews with 54 girls and young women recruited from health facilities and the community, 51 partners and relatives of girls and young women, 31 key informants (community leaders, pharmacists, PAC providers, and policymakers). Twelve focus group discussions were also conducted with youth aged 15-24, as well as with fathers and mothers of adolescents in the community.

Findings indicate that family and individual-level factors play a primary role in increasing exposure to risky sexual behavior among girls and young women, and socioeconomic factors act as key catalysts in increasing their vulnerability. In the study, many girls and young women were found to be living under dire socioeconomic conditions, leading to them dropping out of school to find jobs, and in some cases engaging in transactional sex. We also found that girls were receiving conflicting information from diverse sources about sexuality, with parents being keener on abstinence and encouraging them to disregard the more contraceptive-focused sexual education received from schools, the media, and non-governmental organizations. Furthermore, stigma from healthcare providers and the community, fear of side-effects, and the influence of partners led to low uptake and/or discontinuation of contraceptive use by young people. Together, these factors were found to put girls and young women at further risk of unintended pregnancies.

The decision to have an abortion proved to be complex and non-linear, informed by various reasons and actors. Girls were confronted with the dilemma of choosing between facing the consequences that come with an unintended pregnancy or having an abortion. Either way, the partners were found to be highly influential in their decision-making and girls were often forced to abort when the partner denied responsibility for the pregnancy. A majority of the girls did not have access to information regarding (safe) methods of abortion. Within society, abortion is discussed in relation to its lethal consequences. Such sources as the media, community members, churches, and schools emphasize the risks and consequences of abortion, in particular, focusing on the risk of infertility. Furthermore, the level of stigma around the topic remains enormous. Therefore, when seeking information, guidance, and financial support, many girls who participated in this study – especially those living in rural settings – sought to preserve secrecy. This influenced which people they felt they could approach for information and advice, limiting them to mostly peers or partners. This further affected the type of information they received, the methods they used, and the care they received. Most girls preferred “traditional” methods of abortion, because of their perceived social safety (in terms of discretion) and ease of accessibility. Medical abortion and Manual Vacuum Aspiration (MVA) techniques, on the other hand, were the methods least used, partly due to a lack of information about them and the perception of them being socially and medically unsafe. A majority of the girls in this study opted for the cheapest methods available, which often failed; this drove the girls to explore multiple options, hence increasing both the cost and the likelihood of complications.

¹<https://rutgers.international/programmes/she-makes-her-safe-choice/>

A great number of girls experienced post-abortion complications, yet the fear of stigma and interpretations of the complications delayed them, or sometimes prevented them, in seeking care. At the public health facilities, access to post-abortion care services was hindered by a lack of equipment and trained staff, difficulties in diagnosis, and the high cost of services. In addition, poor treatment, lack of privacy, and lack of involvement in decision making while accessing PAC services were reported as challenges that impeded the quality of care they received. Moreover, findings show missed opportunities around PAC contraceptive counseling due to a lack of counseling from providers in some instances, unavailability of the methods of choice, women failing to return to the facility as requested by the provider, or refusals of girls to use contraceptives due to their partners' influence and the fear of side effects. Because of the ethnographic nature of this study, links between SGBV and abortion came out strongly. The findings showed how it drives unplanned pregnancies (through incest, defilement, and rape), influences abortion decision making (forced abortion) and care-seeking pathways (abusive health workers) through unequal power dynamics, abuse, and coercion. The research points to an urgent need for further investigation and addressing the intersection between SGBV and abortion and what can be done to better address this in the abortion pathways. The study points out the need for clear policies and interventions to address the girls' vulnerability to unplanned pregnancies and reduce the barriers they face when seeking abortion services, especially for cases of sexual violence (as per the Maputo protocol). Further recommendations call for improving the quality and provision of PAC services by ensuring the services are comprehensive, affordable, and youth- and women-friendly, and that there is sufficient trained staff and working equipment in the public health facilities to enhance the use of such vital services in reducing unsafe abortions in the County.

Introduction

The first time I [researcher] met with 19-year-old Pendo was at their extended family homestead. I was introduced to her by a community health volunteer (CHV) who happened to be her aunt. When I arrived, she looked shy; she had worn a dera (a long traditional dress) and cornrow lines on her hair. As we talked, I realized she was actually very talkative and open. She had a boyfriend – she did not know his exact age – who delivered bread from a bakery in town to her village. The first time, they met in a town where Pendo would go and visit her aunt during school vacations. He approached her and asked her to be his girlfriend and she was convinced to accept his request because he would buy her anything she would ask for.

“

Anything I would want he would give me ... if I told him to buy me oil, he would buy me. Many things. If I needed money for school, he would send..., he would buy me a uniform.

”

During the school term she would meet him in her village when he delivered bread to the various shops. They dated for about a year before deciding to have sexual intercourse. The first time they had sex, they did not use any contraception, as Pendo's period had stopped the day before, so she thought she was "safe". One day, as she prepared to go to school, she started vomiting and wondered what was wrong since she was not feeling sick. She had missed her period for a month, and she was worried about the vomiting. She decided to go to school anyway, and after coming back in the evening she decided to go to the dispensary to get tested.

“

...when I vomited, I just knew I was pregnant. I came back [from school], I changed my clothes and then I went [to the dispensary]. I took a jerrican so that I could [pretend to] go to the dam [...]. I went and left the jerrican there and I left. When I was tested, I went back to the dam where I left my jerrican. I sat there, and I didn't even go back [home] with water.

”

Pendo was overwhelmed and at first did not inform anyone about her pregnancy since she did not want to bring shame to her parents, and she was also afraid of how they might react. In the second month, she realized that people had begun to suspect that she was pregnant. Her aunt had informed her mother that she looked like she was pregnant, so her mother asked her why her forehead was shining, a supposed sign of pregnancy. Pendo denied that she was pregnant. She called her cousin, who had procured an abortion, explained the situation to her, and then asked where she had procured her abortion. Pendo's cousin discouraged her from having an abortion because of the risk of death. They decided to call Pendo's boyfriend and inform him about the pregnancy. He also urged Pendo not to have an abortion as he was ready to cater to the child's needs. Pendo, however, was determined to have an abortion as she was not ready to be a mother and wanted to continue with her studies. She also felt it would bring conflict between her and her parents. She was prepared for anything, including abortion complications, as long as she did not bring shame to her family. After negotiating, the boy took her to a clinic where she could get the abortion done.

Pendo's story highlights the journey and reproductive stories of millions of women in sub-Saharan Africa (SSA) when confronted with unintended pregnancy. About 21.6 million unintended pregnancies occur each year in Africa, and nearly four in ten (38%) end in abortion (Singh et al., 2017). Yet over 93% of women

of reproductive age live in countries governed by restrictive abortion laws (Singh et al., 2017). In Kenya, for instance, abortion is permitted only to save the life and/or preserve the physical health of a pregnant woman (National Council for Law Reporting, 2010). The vast majority of women in need of abortion services in such contexts resort to unsafe methods and procedures that can result in severe complications, disabilities, or death (Guillaume and Rossier, 2018; Singh, 2006). In Kenya, an estimated 464,000 induced abortions occurred in 2012, and 157,000 women and girls received post-abortion care (PAC) at health facilities (APHRC et al, 2013). More than 75% of those receiving PAC experienced moderate to severe complications (APHRC et al., 2013).

While the literature is expanding on abortion and factors driving unsafe abortions, significant knowledge gaps exist in Kenya. Aspects rarely investigated for their role in abortion care seeking include cultural and socioeconomic factors, access to information, and the involvement of partners, peers, or others in abortion decision-making and management. Another aspect rarely investigated is the role sexual and gender-based violence (SGBV) plays in the abortion pathways. Also, most research on abortion is conducted in urban centers and often little information is available on how abortion is navigated in rural areas. We also do not know how young women's experiences with abortion change their perceptions of contraceptives and abortion. One of the reasons that these factors are missing from most past analyses is that, in abortion research, research participants are predominantly recruited from the facilities they go to when seeking PAC services, and they usually participate in only one interview. Very few studies adopt in-depth, ethnographic methods over an extended period in various settings (i.e., health facilities and community) to understand the complex factors driving abortion decision-making.

In this study, we adopted an ethnographic approach to document the lived experiences of women dealing with unintended pregnancies. Our key goal was to explore the way they navigate abortion decision-making in their specific social, cultural, and legal contexts, in order to better understand the complexity of the factors leading to unsafe versus safe abortions and how they intertwine to shape the abortion pathways and outcomes experienced by women and girls.

The data gathered in this research are expected to provide insights into the lived experiences of girls and young women as they navigate unintended pregnancies, abortion method choices, and the safer and less safe abortion options available to them. It is hoped that these insights enable health workers, NGOs, and those who make policies and laws to step up their efforts to promote the sexual and reproductive health and rights of young women and girls.

Methods



The research setting

We conducted the ethnographic study in Kilifi County, which is in the coastal region of Kenya. The County has a high rate of adolescent pregnancy and unsafe abortion. For example, the 2014 Kenya Demographic and Health Survey (KDHS, 2014) indicates that 22% of adolescent girls aged 15-19 in Kilifi were pregnant with their first child or had given birth, compared to 18% nationally. The County also has a low rate of use of modern contraceptives (33%), compared to the national usage rate of 53% (KDHS, 2014). Over 20% of Kilifi's adolescent girls are sexually active, with a significant number of them becoming mothers at an early age (Ssewanyana et al., 2018). The community recognizes adolescent pregnancy and unsafe abortion as a problem.

Kilifi County has a population of 1.4 million people. The majority of the inhabitants are Mijikenda, a group of nine related ethnic groups (Rabai, Chonyi, Ribe, Jibana, Duruma, Digo, Kambe, Kauma, Giriama, Pokomo, Bajuni) who speak Kiswahili and other local languages. The people in the County are engaged in various economic activities, such as fishing, farming (maize, cassava and coconut), and small businesses, including food vending, motorcycle taxi transport, and carpentry.

The County is divided into nine sub-counties comprising rural and urban areas. We collected data in two sub-counties, one more urbanized (Kilifi North), and one more rural (Kaloleni). In both sub-counties, the researchers were positioned in one urban and one rural ward to enable the study to capture a variety of perspectives in terms of abortion experiences. The data were collected in four (4) public health facilities and four (4) private facilities, as well as within communities. In selecting the public health facilities, the research team consulted facility data managers and identified two public referral (level 3 or 4) hospitals and two primary level facilities with high numbers of PAC cases². We obtained approval from each facility to have a researcher stationed on site to collect data about individuals. Relevant community data were collected in the areas served by the selected health facilities.

Entering the field

The data collection team consisted of a group of four young researchers who have backgrounds in Anthropology and Sociology. Before entering the field, they were taken through a five-day, face-to-face training workshop. The content of the workshop consisted of an introduction to the project, the study objectives and design, and human research ethics (including the consent process, research on sensitive issues, and ethnography). The workshop also included opportunities for the data collection team to role play and to conduct a pretest. Prior to going to the field, the study team received ethical approval from the AMREF Health Africa's Ethics and Scientific Review Committee (ESRC) and the African Population and Health Research Center (APHRC) ethics review committee. We also obtained research clearance from the National Commission for Science, Technology and Innovation (NACOSTI). In addition, we obtained approval from the local administrative and health authorities, including the County Commissioner, County Directors of Education and Health, health facility administrators, and the chiefs, assistant chiefs, and village elders. These stakeholders were also invited to share their inputs on the research question and the selection of study sites.

In the health facilities, the data collection team members were introduced to heads of the targeted health facilities, who then took them to specific wards and individuals in charge of providing PAC services. At the community level, the introduction of the team was done through the chiefs and village elders, who later connected the researchers to CHVs. It is important to note that the study was introduced at the community level using a broader thematic approach (i.e., adolescents' sexual and reproductive health) to ensure confidentiality and protect the women who agreed to share their abortion experience.

At the health facility and community levels, the challenges varied immensely. First, the team entered the field in the middle of a countywide medical staff strike and in the middle of the COVID-19 pandemic. The strike was due to the medical staff's limited access to personal protective equipment (PPE) during the pandemic. This three-month long strike affected service delivery in the hospital, with only emergency cases being taken in for treatment. Tensions were observed at hospitals, where the few healthcare providers still offering services were overwhelmed and, as a result, were occasionally abusive to patients they could not serve. In this period, we observed that providers did not consider incomplete abortion cases an emergency. Therefore, PAC was not being provided, and patients were referred to private facilities. After the strike ended, patients started streaming in with various complications, among them incomplete abortion.

The integration of the researchers varied within the different facilities. At the Level 3 and 4 hospitals, staff were open to the research and quick to involve the researchers with patients presenting for PAC, including manual vacuum aspiration (MVA) procedures. However, the large number of staff with different work schedules made it difficult to build long-term rapport. In lower-level facilities, the number of staff was limited, and they felt overburdened. In these facilities, the researchers often introduced themselves to staff at night and found that, at first, staff were not so quick to disclose that they treated PAC cases.

²In 2019 and 2020, the two public referral hospitals recorded 99 PAC cases combined, while the two primary level public health facilities recorded 19 PAC cases in total. All private health facilities also offered PAC. It is important to note that these figures may not reflect the true picture of the PAC cases handled in those facilities, given the dynamics surrounding the reporting of abortion cases in health facilities due to the sensitivity of the issue (Suh, 2021).

Rapport and trust had to be built over an extended period and the researchers did so by offering support where they could (see next section). The team also held daily and weekly debriefing meetings with the field researchers to discuss progress, provide continuity in training, and to solve emerging challenges. Halfway through the data collection, the team held a refresher training workshop.

At the community level, the main challenge was related to the taboo around abortion and sexuality. Many of the CHVs and youth advocates (from the county advisory board and others from Reproductive Health Network Kenya-RNHK) were hesitant to support the study and identify research participants. Only a few agreed to collaborate in identifying participants for the research.

Researcher immersion in the field and building rapport

The researchers observed various services offered at the targeted facilities, such as antenatal care, postnatal care, deliveries, outpatient and inpatient services, and casualty. They spent a significant amount of time observing MVA. During the facility observation, the researchers took on duties such as assisting in entering records and helping patients to navigate the facility. During MVA procedures, they would hold the flashlight to enable the doctor to have a clear view of the cervix. Sometimes they would talk to the patient during or after the MVA procedure and listen to their stories. Many times, the MVA procedure was painful to the patient, so the researchers would comfort and encourage them.

These roles were occasionally distressing to the researchers. It was stressful to assist SGBV victims or witness abuse in the healthcare setting, and they also sometimes found the MVA procedures traumatic. We employed various approaches to help the field team cope with these traumatic events. Specifically, we held weekly debrief sessions, and provided professional counseling sessions. In addition, the senior researcher and research coordinator provided one-on-one support.

Observing other services besides PAC enabled us to examine how healthcare providers interact with patients in other units and departments, compared to those seeking PAC services. It also helped us identify 37 patients that were treated for abortion complications. Once identified and their consent obtained, the researchers observed their care process, including their interaction with the providers, as well as with their relatives, while having informal conversations with them. At the end of the care process, the assistants received consent from 16 of the 37 patients to follow up with them within their communities. In addition to following up with these participants in their community settings, right from the beginning, the team spent time observing key places in the community, including markets, hair salons, and restaurants. Team members also sat in on community meetings to learn about local cultural practices and population movements, and to identify potential allies who might support them in reaching out to the targeted participants (i.e., adolescent girls who had an abortion during the study period or in the recent past, and their relatives). While following up with the participants and observing them in the broader community settings, the researchers also took up different roles, beyond research, such as acting as a mentor or counselor to the young girls, especially on how to navigate through puberty, and referring them to healthcare providers in case of need. Sometimes they were asked by the participant to mediate between her and her partner.

The researchers befriended many of the participants, which made it hard for them to leave the field. Thanks to the immersion in the community, the support from the CHVs and youth advocates, as well as the snowballing approach, we identified an additional 38 girls and young women who were followed up throughout the study period. It is important to note that only participants who gave their consent were followed up and interviewed. For those below the age of 18, we did not seek parental consent because requesting parental consent for minors to take part in this study would put them at risk and violate their privacy as many women seek abortion services in secret due to stigma surrounding abortion. We therefore requested and obtained a waiver of parental consent from the ethics committee. Research assistants were trained to take extra care to communicate study processes, potential risks and benefits, and the details of participation to minors, and to do so in familiar language so as to ensure comprehension, particularly of their right to decline to participate.

Interview procedure and profile of the research participants

Through their constant presence in the health facilities and the community, and thanks to the support from healthcare providers, CHVs and youth advocates, we were able to identify and follow up with a total of 54 adolescent girls and young women who had experienced an abortion. The socio-demographic characteristics of the participants are described in Table 1. The initial and follow-up interviews were conducted mainly in Swahili, sometimes mixed with English. The researchers needed to probe more during interviews with girls younger than 18 years, in particular with regards to discussing matters related to sexuality. Nevertheless, the recurring interaction and visits increased the girls' comfort in sharing their views with the researchers. We transcribed the initial interviews, and then used these as the basis for questions for the follow-up interviews.

Table 1: Socio-demographic characteristics of adolescent girls and young women interviewed

Characteristics		Frequency (N=54)
Age (years)	14-17	8
	18-24	41
	25-30	5
Highest level of education	Primary school	18
	High school	28
	College	7
	No formal education	1
Area of residence	Urban	12
	Peri-urban	16
	Rural	26
Marital status	Married/cohabiting	3
	Separated	4
	Never married	47
Occupation	Student	19
	Employed/informal laborer*	19
	Unemployed/housewife	12
	Sex worker	4

* Hairdressers, house girls, bartender, shopkeepers, waitress, tailor, casual worker at the cereals board plant

In-depth interviews and informal conversations were also conducted with 33 relatives of girls and young women who participated in the study, including mothers, fathers, aunts, uncles, sisters, friends, grandmothers and grandfathers. The interviews and discussions focused on, among other issues, their relationships with the girls and young women, their role in the decision-making and care-seeking pathways, and the rationale that guided their role and involvement. These relatives were only contacted after obtaining consent to contact them from the main research participants. We also conducted in-depth interviews with 18 partners of girls and young women who had an abortion. Four were partners of the young women interviewed in the study. Others were recruited separately through the CHVs or providers. They ranged in age from 18 to 35 years. The interviews with partners were aimed at documenting their perspectives on their partner's abortion pathways, including the type of the relationship in which they were involved, practices around pregnancy prevention, their reaction to the pregnancy, and their role in the decision-making process, as well as in navigating the care-seeking pathways.

The interviews with the women, as well as their relatives and partners, were complemented and triangulated with interviews with and observations among various key actors in abortion pathways and the broader SRHR field in the County. These actors are presented in Table 2. The observations, interviews and informal discussions with these actors focused on understanding their role in abortion and post-abortion services provision in Kilifi County, including their rationale, the challenges they encounter, their views on the policies and guidelines affecting the provision of abortion services, and their take on the need for training and equipment in health facilities, among other things. The participants were identified through our immersion in the targeted facilities and communities using a snowballing approach.

Table 2: Key informants interviewed

Characteristic		Frequency (N=31)
Role/position	Community health volunteers	4
	Community leader	1
	Healthcare provider (public/private)	11
	Pharmacists/drug vendors	6
	Traditional birth attendants	3
	Policy makers	4
	Teacher	1
	Prosecutor	1
Sex	Male	17
	Female	14

We also conducted 12 focus group discussions (FGDs) in the two sub-counties, three in each research site. Four FGDs were held with mixed groups of young males and females aged 18-24, four with mothers and four with fathers aged 30-55 in the community. We framed the research topic more broadly to protect the adolescents and young women involved in the study. The FGDs covered various topics, including the social and cultural dynamics in which abortion is embedded, the transition to adulthood, community perceptions of adolescent pregnancies and single motherhood, parents/adolescents communication, reproductive decision-making, and induced abortion (awareness, local terminologies, and drivers). The discussions were mainly conducted in Kiswahili and Giriama languages.

Data management and analysis

All formal interviews and group discussions were audio-recorded following consent from participants. Audio files and field notes were anonymized, and stored in a password-protected Google Drive project folder with two-step verification. Audio files were transcribed verbatim and translated into English. The development of the coding scheme and subsequent analysis were both theory-based (departing from the initial proposal) and data-driven (based on additional themes emerging from the data). The data were coded using Dedoose software by three full-time coders working in collaboration with the rest of the team. After checking for consistency in the coding approach, the team members proceeded to code independently. While coding, the team met weekly online to discuss emerging codes or duplication and get feedback on sections where codes were uncertain. The findings are presented using verbatim quotes, both from interviews with participants (using pseudonyms to protect their identity) and from observation notes.

Findings



I. Factors contributing to unintended pregnancies

Mwache is an 18-year-old young woman that I [researcher] met during her visit to the facility in March 2021. She had been brought in by her mother. She walked in the facility dressed in a dera (a traditional long dress) and covered in a lesa (a piece of fabric used by women to cover themselves). Her hair was braided in cornrows, and she had white rubber shoes. Mwache had completed primary school but had not continued with secondary education because her father had died when she was still young, and her mother had limited financial resources. When she was 16 years old, she decided to go to the nearest city to look for opportunities. She has been working for a family for two years. She was introduced to her employer by her neighbor who also works in the same city.

She was in a relationship for a few months with a man who is a soldier in the Kenya Defense Forces. I asked her how old he was, and she replied:

“

Honestly I don't even know how old he was. Our relationship wasn't like 'normal' relationships. I was in the relationship not by will but because I needed the money he gave me and I was influenced by my friends to be in it. He would give me money that I would use to buy myself things. At first the relationship was good and he treated me well; he took me to nice hotels.

”

Mwache reported that she did not know about contraceptives and therefore used the rhythm method as she was advised by friends to avoid getting pregnant. This helped her until she missed her periods one day and learnt that she was pregnant. The relationship ended when she informed the man that she was pregnant.

The case of Mwache, quite like that of many girls and young women, sets the scene to understand the factors driving girls' vulnerability to unintended pregnancy in Kilifi County.

The socioeconomic conditions of girls and young women

Participants lived in varied social and economic conditions. Most of them were living in a homestead set up with extended family members, including grandparents, uncles, aunts, cousins, and other relatives. This was especially common in the rural settings (Matsangoni in Kilifi North and Gotani in Kaloleni). In the urban areas, the family setting was quite diverse ranging from orphans living with their grandparents, single-parent households (both female-headed and male-headed), two parent households, and living with extended families in one compound. For instance, 6 out of 54 girls were orphans and they lived either with their grandparents or siblings, while others lived alone. Many girls also came from single parent households and explained that their guardians had left them under the care of the grandparents to go look for work in towns or to travel to Middle East countries in search of greener pastures. This was especially evident given the harsh economic conditions in Kilifi County, particularly after the collapse of the tourism industry because of the COVID-19 pandemic:

“

Look at this girl [she points at one girl]. If her mother was around taking care of her, she would not be going through all these. Now nobody will commit to living with her because they also have their own children to take care of. The girls are idle at home, and they are poor, so there is nobody to watch over them. Many of these girls are not even raised by their parents. They stay with grandparents who have many other grandchildren to look after so they can't even go to work. So many girls have given birth and gone to get married during this COVID period. It is sad to see. (25-year-old Salonist, Community Observation, Urban setting).

”

Most research participants, both in rural and urban areas, come from poor backgrounds. Their parents and grandparents were often poor and had menial jobs or no job at all in some circumstances. Consequently, as illustrated in by the following quote, a substantial number of young women and girls dropped out of school because their parents could not pay school fees:

“

I went to school up to form two then I dropped out. We are two in our family and at that time, we couldn't get fees for both me and my small sister, so I had to drop out of school for her to finish her studies. So I started working here so that I can provide for my family. (23-year-old, Single, Sex worker, Urban setting).

”

As highlighted in the quote above, the economic situation of their parents and relatives pushed most girls (especially those who were out of school) to seek jobs that could provide them some income. In total, 19 of the 54 girls and young women were working. The most common activity was casual labor, which included odd jobs such as informal business, washing clothes, doing house chores for different people, doing casual farm work, weaving palms leaves, removing and selling cashew nut shells, selling palm wine, and sometimes fetching water for people in the village. Other jobs mentioned include bartending, waitressing, housekeeping, shop assistant, casual health facility worker, job agent, hairdressing, and sex work. On average, the girls and young women reported that the casual labor jobs would earn them between KES 100-300 (~USD 1-3) per day, and this often depended on the availability of work. The little income generated from these jobs was essential to meet the participants' needs for such things as rent, food, sanitary towels, and clothing. Some participants also reported that they were using their income to also take care of their children, younger siblings, or grandparents.

According to participants, the precarious socioeconomic situation increased the likelihood of engaging in transactional sex, including dating older men, boys from families that are financially stable, or boda boda riders who can meet their financial needs. Ruth, a 16-year-old schoolgirl, explained to us how her father was *"very irresponsible and would leave us without food, especially when we wrong him, or he is drunk, or at times he would just go and eat from kiosks and not care for us"*. In addition to denying them food, her father was not paying their school fees and her mother, who used to do it, had to stop because of other priorities. For her to remain in school (unlike her siblings) and sustain her basic needs (such as sanitary pads or cosmetics) she had to sell brooms and rely on money given by her boyfriend.

Likewise, 27-year-old Martha, a single mother who was working in a bar, ended up in sex work to improve her living conditions and support her family. She narrated how sex work exposed her to abuse:

“

... they get drunk and ask you to accompany them to sleep with them. They assume we are all prostitutes and if you refuse, they just start abusing you. And we can't do anything about it because like me I depend on this work to pay my bills and even pay school fees for my siblings. (27-year-old, Single, Sex worker, Rural setting).

”

In the FGD with parents, participants blamed caregivers for pushing the girls (both directly and indirectly) into such situations so that they can help the family with food or sometimes get money for sanitary towels, school fees, and accommodation, as well as other personal necessities. A father shared:

“

I got a story that really shocked me, but I judged myself for it. Because when my daughter was in her 3rd year, she was told to leave the hostels; so that she can give a chance to the fresher's [first year students] who are joining. I needed to have KES 12,000 fast so that she could secure a house. I looked for that money but did not find it. So, my girl had to look for someone to sponsor her in school. She got pregnant. (...) Her mother asked, "How did you get it?" Then she said, "It is what you see." I told my wife, "The mistake was ours because she told us in advance. Kisumu is very expensive and so she had to get a sponsor. (Fathers' FGD, 57-year-old, Married Businessman, Peri-urban setting).

”

Sexuality education and contraceptive use: a space filled with conflicting norms

While girls and young women are transitioning from childhood to adulthood, they receive information about sexuality and reproductive health from family members, religious institutions, schools, NGOs, media, CHVs or peers. Highlighting different sources of information, one stakeholder explained:

“

The county is very vast but also the county is well innovated in terms of community units. Much of the information is passed through the community health volunteer; that is the biggest segment of information dissemination. Then you can divide the other into media where we have radio, we have local radio stations, where we have a lot of information on radio, [...] We also have other avenues like the peer educator networks. So that we have a ward-level young people's group, then the sub-county and at the county the youth advisory council. (County Reproductive Health Representative, Kilifi).

”

From our FGDs and interviews with relatives, we found that in the past, parents, especially mothers and grandmothers, were involved in educating their children about sexuality as they were transitioning into adulthood. The practice around this activity in the Giriama tradition was referred to as Dhome, which is a gathering where grandparents and older people would advise younger members of the community. The gatherings were held separately for boys and girls. As part of the information provided, girls were taught about menstruation and warned against “playing with boys” after getting their first periods. They were also taught about the “dangers” of having sex. Some parents explained that this practice is still relevant and ongoing, but in a sort of individualized manner, with parents (mothers with girls and fathers with boys) and community elders providing such education to girls who reach puberty.

However, other parents noted that the practice of Dhome and parental-children conversation has dwindled over the years. These parents blamed this on their children's schooling and subsequent separation and distancing with parents, as explained by one parent:

“

This Dhome has stopped because of [schooling]. Schooling is good but it has brought a lot. Because this child gets to where she says that she is at home studying, while she is not even at home. It has even confused us because an old person will light the fire and stay alone as the child says she is studying. (...) That one has contributed a lot to why we cannot sit together. Because our teachings are to educate you personally on how to live tomorrow, but because she has joined the life of studying, then she will be different. (...) You feel pity, but feeling pity now it will reach a point when it gets to that stage when you know this child of mine, has gotten to where she has started puberty if she's a girl, if he is a boy, he has gotten to puberty, you want to look for somewhere where you can teach him two or three things but you can't because where he is, he is staying far from you.” (Fathers' FGD, 64-year-old, Married Casual Laborer, Rural setting).

”

As highlighted above, parents complained that students have too much homework from school and they often lack the time to have a sit down with their children in the evenings, while young participants complained about their parents being too busy with their work and adults' issues to sit with them for a conversation. Additionally, the parents revealed that, due to advancement in technology, children are engrossed with their phones and have no time to talk with them, and they also use these phones to have secret meet ups with boys without their knowledge.

The parents pointed out the conflicting nature of the information provided by “modern” sources, which according to them encourage girls to have sex and use contraception to avoid pregnancy. In response, parents who still manage to talk to their girls, request them to disregard information obtained from

schools and follow their advice instead, or they try to nuance or temper the information obtained from schools while emphasizing the risks of sex and the need for abstinence. This is stated by one of the participants from parents' FGDs.

“

We tell them, (...) first if it's playing with these boys, it's not playing football. Don't sleep around with these men because you study and from your studies in class four you learn about having sex now you have to come from your small thoughts. You should not say that the teacher taught me this, I have seen this, I now have to try out, because once you start receiving your periods you will have been taught everything. As your mother, I will tell you that, whatever you have been taught in school, don't go about putting it into practice. That was taught to you for knowledge but if you go about putting it into practice you can get pregnant, you can also contract diseases. (...) So, don't sleep around with men." (Mothers' FGD, 47-year-old, Married Tailor, Rural setting).

”

Perceptions and practices regarding contraception

We found out that adolescents and young women learned about contraception from different sources, such as schools, churches, relatives, and peers. The same is true for other pregnancy prevention interventions. For example, the Ministry of Health had a “youth fix day” where adolescents and young people come for services and interact with healthcare providers. Interviews with actors from the Ministry of Health showed that the Ministry has peer education programs to provide young people with modern contraceptives that are easily dispensable, including condoms, emergency contraceptive pills, and the combined oral contraceptives. The Ministry also hosted Adolescent and Youth Sexual Reproductive Health meetings (AYSRH) in the community where adolescents and youth could meet with healthcare providers.

The content and depth of the information received by adolescents and youth varied by source. Some young women reported having received detailed information on family planning, what contraceptives are, and/or the type of contraceptives available. Others reported that they were just told about family planning or contraceptives, with a focus on condoms. Some young women were only warned against using contraceptives, with an emphasis on the risks associated with its use [i.e., infertility, sexually transmitted infections (STIs)]. Therefore, although most adolescents and young people interviewed had heard about family planning or contraceptives, they often had insufficient information or knowledge to decide on whether to use them or not, or even where to get them. They were left with unanswered questions, such as: Was it really meant for them given that it is about “planning a family” and they do not yet have families? Are the risks being discussed in the community real? And which methods are adapted to or most appropriate for them? Because of this information deficit, they often relied on their friends, siblings, other relatives, or partners for (additional) information that may not be accurate.

“

I: At that time, what kind of information did you have about methods of being safe? Did you have any information?

P: I did not have knowledge of anything. I did not know people are supposed to use protection.

I: And he himself, did he know?

P: Yes, he knows because he is a grown up.

I: The times when you were meeting, were you talking about protection?

P: Yeah, he used to tell me, but you know these things when you are used to them, it is easy to understand, but when you don't know, then it is difficult. (24-year-old, Single, Manual Worker, Rural setting).

”

Taken together, these factors – the contradicting or incomplete information to which young people had access – influenced contraceptive use by adolescent girls and young women. Further, conflicting information creates some tension when it comes to making decisions on how to negotiate risks, especially relating to the use of contraceptives.

We found low contraceptive use among young women and girls. When asked what method of contraception they were using before getting pregnant, most reported that they were using condoms, and yet condom availability and use was reported to depend mainly on the male partners, i.e., whether he was willing to use them. Some also reported using emergency pills (called P2), and sometimes doing so on a regular basis instead of using them only occasionally as an emergency pill. There was a tendency to go for a method that was easily available among the youth, as highlighted by the following quote:

“

I can say for us boys we prefer condoms as it's the easiest and they are even given for free in the hospitals. But if you don't use condoms the safest way is to take P2. (Youth FGD, 22-year-old male, Single, Waiter, Rural setting).

”

Other participants were practicing abstinence or using traditional methods, such as herbs/plants (i.e., mustard seeds), while others were counting their days or using withdrawal as reported by one of the participants. After she experienced a pregnancy, she first decided to abstain, and later went for withdrawal and condoms:

“

After getting pregnant I asked him what we can do because as for me I had promised myself that I won't have sex again if life was still going to be the same without the use of contraceptives. Later, we started communicating and continued with our relationship. I went the first day, but nothing happened. There was the urge to have sex, but we had to discuss on what to do to prevent pregnancy. He suggested family planning, but I declined since I had no family. So, we mostly use the withdrawal method and a condom even though he doesn't like using it. (22-year-old, Single, College Student, Rural setting).

”

Reasons for not using contraceptive methods

The stigmatization of contraceptive use by adolescent girls and young women was identified as one of the factors leading to pregnancy among the study participants. We learned that the use of contraceptives by young and unmarried girls was highly stigmatized in the community. Those using contraceptives are considered promiscuous.

“

I'd say in our community there are names given to such girls – kitombi, to mean she is loose. When people know that a girl is using contraceptives, they perceive her to be having multiple sexual partners and everything bad surrounding that. But we are different. Personally, I'd take such a girl to be one that understands herself and she is preventing herself from making the mistake of getting pregnant, while others may see her as one who does not understand herself and is immoral. (Youth FGD, 21-year-old female, Single, Student, Rural setting).

”

Most girls, fearing such stigmatization, reported not using contraceptives because of how they would be seen by their relatives and/or members of the community. Those who had the courage to visit health facilities also experienced stigmatization from the providers, which deterred them from obtaining the

methods they had in mind, or sometimes any method at all. Some girls reported that they could not get the methods they were seeking because they were not available, especially during the providers strike due to the COVID-19 pandemic. At one of the facilities, the regulations were that women and young girls should get tested for HIV before accessing contraceptive methods. To avoid getting tested, girls and young women either left without any contraceptives or sought services in private facilities. One of the girls also explained how the provider tailored the counseling to discourage her from using long-term methods:

“

That nurse has explained to us about family planning. She said that for 5 years they insert it on the arm, and also for 3 years. But she told us not to use them because they are long term. She said they are to be used by grownups who already have children and do not want to get more anytime soon. So, she told us to use the pills or the 3 months injection. So, we decided to use the injection because where will we put the pills at home? You will find the parents will know or people will see you taking pills every day and wonder if you have HIV. (19-year-old, Single, Primary School Student, Rural setting).

”

She ended up discontinuing her use of the three-month injection, as it required frequent visits to the facility, and that carried with it many implications, such as finding the time as a student to visit the facility, the risk of running into someone there that she knew, and the financial cost.

Participants also noted that the fear of side effects, such as becoming infertile, hindered the use of some contraceptive methods. One participant, a 16-year-old primary school student, who was using injectables decided to stop after one use when she heard stories about contraceptives not being *“good for us especially for young girls since when you get married you will experience difficulties when trying to get pregnant.”* (16-year-old, Single, Primary School Student, Rural setting). Other side effects mentioned included weight gain or loss, loss of libido, nausea, excessive bleeding, or irregular menstruation. Some participants mentioned that they did not like using condoms because the lubricant on the condoms causes stomach aches.

The nature of the relation between a girl or young woman and her partner also influenced the decision to use a contraceptive method. In some cases, girls and their partners believed that the relationship was *“serious”* enough for them to have unprotected sex. *“Serious”* meant, for instance, having plans to get married, and therefore ready to handle the consequences of unprotected sex, including pregnancy. Moreover, we found a few situations where the decision not to use or to stop using contraceptives was made because the woman or her partner had a desire for a child. Maua, a 25-year-old participant, had been keenly using the three-month injection since she did not want to get pregnant out of wedlock. After her traditional wedding, her husband repeatedly expressed his desire for a baby of his own. Maua finally decided to stop getting the injections and immediately got pregnant. However, difficulties in her relationship with her husband pushed her to terminate the pregnancy.

As in Maua's case, we found that men were involved in matters concerning contraceptive use and would often have an opinion on the use and non-use of contraceptives. While some partners would put pressure on their girlfriends to use contraceptives to avoid problems related to pregnancy, some men discouraged their partners from using them because of their perceptions regarding the methods. In the FGDs, the men expressed the following about women who use contraceptives:

“

What I know, if you have not used family planning or don't use those pills, speaking the truth you have a different 'taste' (in sex). If you start using injection or taking pills, speaking the truth unless you get a man who has never had sex. But if you get a man who has experienced sex before, he will start having questions because you will not have the female 'taste'. These drugs make your body unazizima (lower libido). (Fathers' FGD, 41-year-old, Married, Construction Worker, Rural setting).

”

Based on such beliefs, some men would propose natural methods, such as withdrawal or safe days, which then lead to unintended pregnancies as reported by one of the girls interviewed:

“

He said that he does not like them and that they make a woman cold and come with some complications, but after the abortion incident I have been thinking about ways to avoid a repeat of it. (18-year-old, Single, Primary School Student, Rural setting).

”

Nature of the sexual relation in which girls and young women were engaged

We documented the type of sexual relation in which the girls were involved at the time they got pregnant. Findings show that 31 of the 54 girls and young women in the study were dating boys and men of similar age, 10 were dating married men, one had a casual relationship, four were raped or defiled, four were sex workers in relationships with their former clients, and four did not disclose any details about their partners. Figure 1 summarizes the type of sexual relation that girls and young women had at the time of pregnancy.

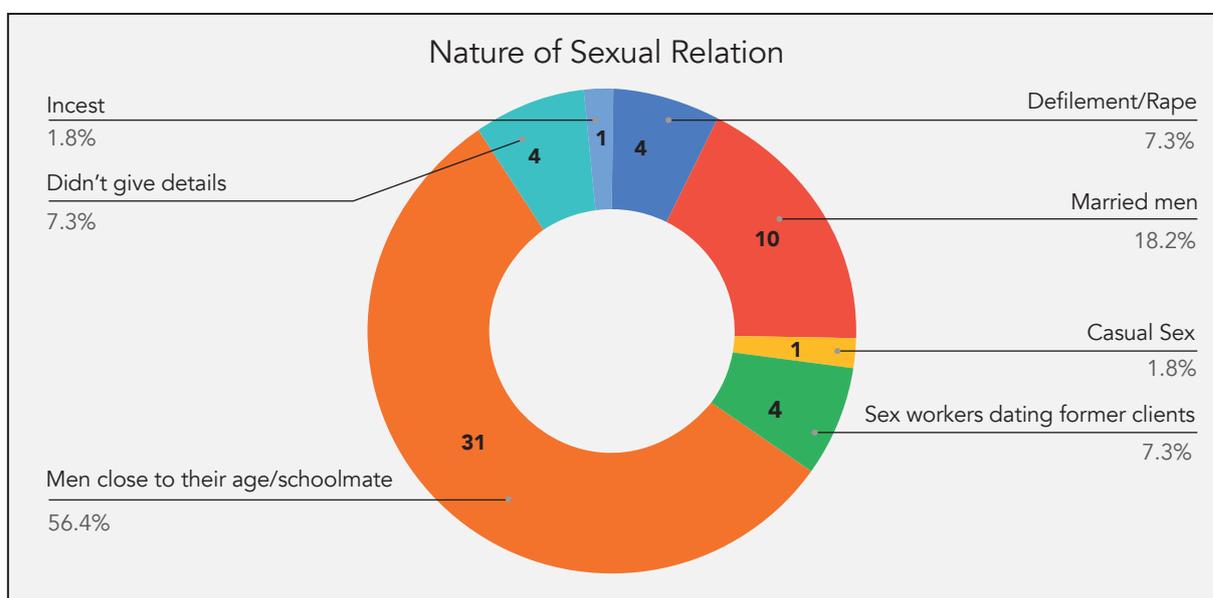


Figure 1: Nature of the sexual relation at the time of pregnancy

Many school-going girls were in relationships with their schoolmates or boys from the same village. These relationships often started during school holidays. For some, they started during the long school closure brought about by COVID-19 pandemic.

“

It was during the corona time, where I had this boyfriend, but he had finished Class 8 in 2018. We were together before in primary school, but his home is in the village. So, he got work to sell at a shop, a shop that sells milk, a normal shop and we became friends. So, I used to go to the shop since he used to sleep there. It is a shop in front but then there was a bed inside. So he used to sleep there, he was living at the shop. (16-year-old, Single, High School Student, Rural setting).

”

Some school-going girls were dating older men, some of whom they reported coerced them into a relationship, as highlighted in the quote below:

“

He is a shopkeeper, he used to work at some nearby shop but after the pregnancy incident he ran away to his home in another village. (...) I had gone to a night disco wedding party so after the party while we were going back home, he asked me to accompany him to his place, which is the house he used to live in near his shop. That is when he forced me to sleep with him and so I got pregnant thereafter. (16-year-old, Single, Primary School Student, Rural setting).

”

Nearly all the girls and young women (especially those who were unmarried) reported that they engaged in sexual intercourse following pressure from their partner. In some instances, school-going girls reported never having consented to the relationship. In the study, we had one case of incest where a 20-year-old school-going girl was abused by her father, who later forced her to abort the pregnancy. In addition to this, three participants aged 14, 15 and 16 were also defiled. Neema was one of them:

“

Last year during the school break in December I met with this man at his shop that is near our home, he asked me to go in and he started caressing my breast and told me that I am beautiful. He then pulled down my skirt and pants and had sex with me. He then gave me 200 shillings and told me not to tell anyone. (16-year-old, Single, Primary School Student, Peri-urban setting).

”

Defilement was widespread in the area. As an example: during the study, there was a highly publicized defilement case going on in court, and it was a well-known case as community members brought it up during conversations around sexual violence. The case also came up during a conversation with a health provider: *“He then mentioned the highly publicized case of the pastor who took in girls from poor backgrounds under the guise that he is mentoring and giving them scholarships and repeatedly defiled them. He is currently facing 18 charges from 18 girls, 7 of those girls are currently pregnant.”* (Observation notes, Peri-urban setting).

The various factors contributing to unintended and unwanted pregnancies among girls and young women in the study are summarized in Figure 2.

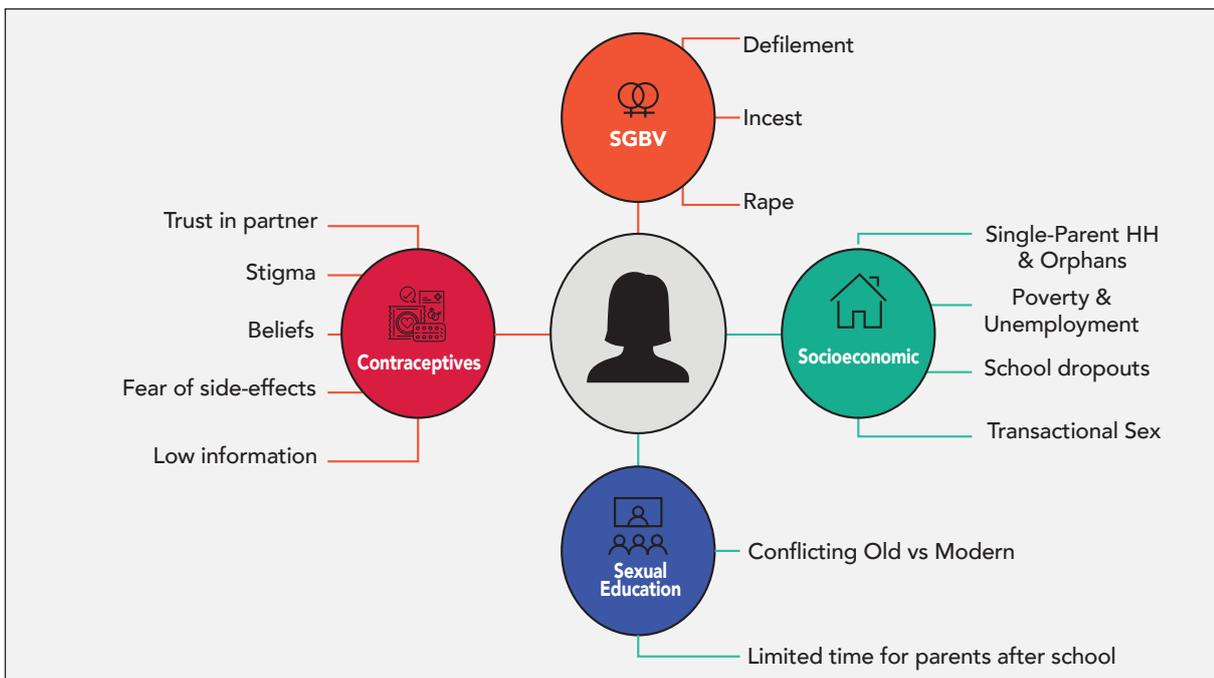


Figure 2: Factors driving unintended pregnancy among participants

II. Decision-making for abortion: a matter of choosing the lesser evil?



Our findings show that the decision-making process on whether to keep an unintended pregnancy normally begins with recognizing the pregnancy, and that this first step then determines how fast the decision will be made and who will be involved in the process.

Pregnancy recognition

Most study participants initially suspected being pregnant due to experiencing various physical symptoms. In most cases, the first sign that participants recognized was missing their periods for a month, and in a few instances, two to three months. Additionally, many participants experienced physical symptoms that made them suspect that they were pregnant, including nausea, vomiting, fatigue, stomach aches, a changed appetite, dizziness, and tender or sore breasts. In some cases, the participants still doubted their condition and they would describe the symptoms to a

trusted friend or family member who would point out that these symptoms could indeed be indicative of pregnancy:

“

I saw that I did not have my MP (menstruation period) in my first month. I was worried, “Why am I this way? I haven’t seen my MP, why?” When I was in school, I asked my friends who told me: “If you did it, know that it is there. However, before that, you will have to go to the chemist for a PT (pregnancy test) to test.” That is what I did. I tested and found out that I was pregnant. (20-year-old, Single, Job Agent, Rural setting).

”

In a few rare cases, close older family members would be the first ones to recognize a participant was pregnant. When space and privacy were limited in the household (as was the case for many participants), family members could more easily notice changes in the menstrual pattern of the participant or physical signs that could indicate a pregnancy.

After suspecting they were pregnant, most participants took a pregnancy test. Testing for pregnancy was either done in a public or private hospital, or at home after buying a pregnancy test at a local dispensary or pharmacy. The costs of the pregnancy test usually ranged from KES 50 to 100 (~USD 0.5-1) per test. When the participant did not buy the pregnancy test herself, it was usually her partner, a close sibling, or a friend who would buy it on her behalf. Information on how to use the pregnancy test was sometimes provided at the pharmacy, but in other cases, girls sought help from a friend, a sibling, or from their boyfriend to figure out how the test worked. In a few cases, participants were unaware of their pregnancy status and were admitted to the hospital suspecting a disease (e.g., malaria) and found out they were pregnant after further tests were done. Overall, the social network of the participants often played a significant role in the process of pregnancy recognition and confirmation. Either the partner, trusted family members, or friends were involved as confidantes with whom initial suspicions about the pregnancy status were shared or by offering financial support to purchase a pregnancy test or to visit the hospital.

Reaction to pregnancy

During the process of pregnancy recognition and after confirming a pregnancy, study participants experienced a wide range of emotions. It was common for participants to describe that they “felt bad”, stressed, sad, uncertain, worried, and confused. In some cases, participants would feel ashamed or scared of the reactions of others to their pregnancy.

“

I felt like committing suicide because I had no previous incidents with men, my mother loves and trusts me a lot, so I felt the pain of shaming her, but no one knows about it. (29-year-old, Single, Unemployed, Rural setting).

”

Many of these emotions stemmed from the participants feeling they were not “ready” to give birth to a child and that the pregnancy was unplanned. Many participants considered the consequences the pregnancy might have on their future and felt distressed and confused about what to do. In extreme cases, participants felt depressed and suicidal and not able to deal with the uncertainties that the unplanned pregnancy brought forth.

Sharing the news

When participants in the study found out they were pregnant, some of them opted to share the news with specific people in their social network. Participants did so to seek advice or to ask for help in seeking abortion care. Trust was often an important factor that influenced the decision about whom to tell or to ask for advice and help. Therefore, participants often chose to share the news with someone belonging to their inner circle. The father of the child, a female family member, or a close friend were often the first to be consulted: *“She was my friend [...] we used to share a lot since we trusted each other, so I knew she was the only one to keep my secret.”* (22-year-old, Single, High School Student, Rural setting).

When girls and young women sought advice from people outside their inner circle it was because they wanted to keep the pregnancy a secret from their close family and friends or because they thought the person would have more knowledge about, or experience with, unintended pregnancies and abortion: *“I knew her through my other friend but not my close friend. She is a friend that I see in the community and greet her. However, I just opted to ask her. Maybe she knew. She was a bit older than me, so she knew more.”* (20-year-old, Single, Job Agent, Rural setting).

Participants were very selective with sharing their news and often kept their pregnancy a secret from those they anticipated would react negatively to them being pregnant or to them opting for abortion. Fear played a major role in the decision to keep a pregnancy hidden. Participants frequently shared that they feared verbal or physical abuse from their parents, siblings, or other family members, or being evicted from the family home if their relatives found out. This is explained by one of the participants:

“

I: Why were you worried?

P: If my mother knew, I will be beaten until...(laughter)

I: The worry was only your mother knowing or what was it?

P: Yes. If she knew I would be beaten, and I didn't want that.

(18-year-old, Single, Primary School Student, Rural setting).

”

Aside from family members, participants also worried about the reactions from friends, neighbors, or other community members. For that reason, participants would conceal their pregnancy to avoid social stigma, being gossiped about, or to prevent their family from being shamed by the community: *“You know you can’t tell anyone about it because, yes, I have friends, but my friends also have other friends. So, I can tell my friend, but they also go and sit down with their friend and tell them my issues, so I don’t tell people.”* (24-year-old, Single, College Student, Rural setting).

Reasons for deciding to terminate the pregnancy

Girls and young women decided to terminate their pregnancies for various reasons. We describe the main reasons below:

Completion of school

We found that the desire of girls and young women to complete schooling was a motivation for abortion among the school-going participants. Although pregnant girls in Kenya are allowed to stay in school by the school re-entry policy passed in 1994 (Republic of Kenya, 2007), girls and young women feared the stigma associated with being pregnant while in school. Some girls mentioned that it would have been shameful to go to school while pregnant, and thus they would have voluntarily dropped out, while others indicated that they would have been forced to drop out by their parents who would have stopped paying their school fees or forced them to get married instead.

“

I would have been chased away and forced to marry or still my sister would have stopped paying my fees because she always tells me to be careful and that I do not get pregnant, so I would have to stop schooling and get married. (18-year-old, Single, High School Student, Rural setting).

”

Many girls dreamt of completing their school and having a good job to make their parents proud and to support them. Some girls spoke of the sacrifices made by their parents to send them to school and saw themselves as an investment that needed to bear fruit by them staying in school and succeeding. In most cases, the girls and young women's fears about the impact of pregnancy on their studies were driven in part by the considerable stigma associated with premarital pregnancies.

Stigmatization of premarital pregnancy

Community perceptions and stigma similarly played a role in the decision-making pathway of unintended pregnancies. The perceptions were tied to societal expectations, as well as gender and religious norms. For example, women are expected to be married before they get pregnant, and girls who have premarital pregnancies are often shamed. One participant highlighted some of the demeaning words used to describe girls who had pregnancies out of wedlock:

“

Kisurukutu wa mitaani (someone who likes boys), lilishindwa (you lost), bwege (irresponsible) maballer (party lovers), plus one, kware (sex lover), malaya (prostitute). Some called me kicheche (wild) and some called me vipikipiki (community bikes), kiruka njia (one who jumps from one man to another), mzinzi (sinner because they sleep around), uwanja wa mazoezi (practice pitch). (Youth FGD, 18-year-old female, Single, Farmer, Rural setting).

”

Girls and women also experienced isolation, as illuminated by a young male participating in one of the FGDs:

“ Such people [women and girls who get pregnant] are not respected in the community, they are normally isolated and are not even allowed to interact with other girls...and for those that she interacts with, she is perceived to be spoiling them and most of the time it is said they will end up like her. (Youth FGD, 24-year-old male, Single, Waiter, Rural setting). ”

The blame and shaming of unmarried pregnant girls extends to parents as well. Mothers are blamed most of the time because they are expected to guide their daughters.

“ When girls get pregnant or have bad behavior mostly the blame goes to the mother. So most say, the old say, that when a girl gets pregnant, they are beaten together with their mother. Or you are chased, the mother goes back to her home and this girl is told to either go to who impregnated her (Community Elder, Rural setting) ”

Therefore, girls and young women being raised and socialized in such a context and witnessing the experiences of other girls, would hide their pregnancy and go for an abortion, as explained by a 24-year-old young woman from a rural setting: *“I had fear of, let's call it stigma. I was in Form Four. I had endured all that time, now when I am almost done is when I am carrying the pregnancy. ‘How will society take me? I will bring shame on my mother.’ Things like those are what was in my head. Now, all I wanted was to abort, the sooner the better.”* (24-year-old, Single, Businesswoman, Rural setting).

Socioeconomic factors

In other cases, the findings show that some participants decided to abort because of their economic situation. Unintended pregnancies were detrimental to earning a living because having a child would mean stopping work to care for the child. For sex workers, pregnancy would mean an interruption of their activity as clients would not want to interact with them while they are pregnant. As illustrated in the following quote, other participants who already had children felt that adding another child would be challenging economically, and they did not want to bring other children to the “suffering”:

“ I informed my husband and he told me he wasn't ready to have another child since we were struggling financially. He said I should decide what I wanted to do but he wasn't ready to care for another child. (23-year-old, Married, Businesswoman , Urban setting). ”

Reactions of partners and influence on decisions to abort

The reactions and advice of the partners who were consulted by the participants after sharing the news about their pregnancy played a significant role in the decision-making process. A few partners, mostly husbands, accepted the pregnancy and encouraged the participant to keep it, since they were willing to (financially) support the participant and the child. *“With John, I told him that I am pregnant. He said I should not abort it, I should give birth and we will raise the child.”* (18-year-old, Single, Primary School Student, Rural setting).

However, in most cases, male partners were angry and/or declined to take responsibility for the pregnancy, which had a strong influence over the abortion decision. *“Immediately I called him and told him that I wanted us to meet, and so when I went and told him, then he denied being responsible for the pregnancy and told me to go find the one responsible.”* (18-year-old, Single, Primary School Student, Rural setting).

In some cases, participants were told by the partner to terminate the pregnancy, and threatened to end the relationship. In other cases, partners explained that they were not ready or that having a child does not align with their goals and aspirations for the future. When partners expressed these concerns, some girls felt pressured to terminate the pregnancy, even when they themselves did not want an abortion. Mary, an 18-year-old participant in an urban setting, for example, did not want to terminate her pregnancy, though she also thought she was not ready to have a baby as she was still not married. She also feared dying from abortion, not being able to have another child when ready to have one, and the stigma that could come from people knowing about her having an abortion. However, when she informed her boyfriend, he told her that *“he doesn't want anything to do with the pregnancy and requested that I abort”*. This forced her to change her mind and she decided to terminate it to avoid having to handle the pregnancy and the child alone, as well as the subsequent stigma.

Influence of other actors

Even though the father of the child was often the first person that girls and young women spoke to, the advice and reactions of other people were also considered in the decision-making process. The reaction and advice these actors gave often depended on the way they perceived abortion and the situation of the participant:

“

I talked to one of my cousins from home. I called her and explained it to her because I did not have a job. The jobs I do are just these small ones. Then, when I said I am getting a baby and you know my situation, she told me then just remove. (24-year-old, Single, Manual worker, Peri-urban setting).

”

Girls often reached out to their mothers. In some cases, mothers advised their daughters to keep the pregnancy when they feared the complications an abortion might cause, the negative reactions the participants and her family might receive when others found out she procured an abortion, or because of their own (religious) beliefs. Other mothers would advise their children to terminate the pregnancy when they thought their daughter would not be able to raise the child, when the pregnancy would interfere with her education, or to prevent the stigmatization that comes with an unintended pregnancy.

“

I: When you found out that you were pregnant, who did you tell?

P: My mother, she is my closest person and she told me...she got pressure, a normal thing with parents. Then the person who was responsible when he refused, my mother said I have no option but to do that (abort) because it will be a shame to our family, though we need to get a doctor who is very careful in that side because here there are two things, either you die or survive. I thank God I found a doctor who was good (20-year-old, Single, Casual Worker, Peri-urban setting).

”

Forced abortions

There were four cases where the pregnant girl or young woman did not participate in the abortion decision. In three of the four cases, the girls had been defiled, and in the last case, the girl was dating a married man. In all these cases, the girls and young women were forced to take drugs against their will. In one case, the girl explained she was kidnapped and taken for abortion against her wishes:

“

When I was going to school, I was taken by two people, a man and a woman on a motorbike. They forced me to go with them, so when they took me, I was not comprehending anything. (...) They gave me some medicine. But I refused to take it. So, they put it in water, held me down and forcefully gave me. (15-years-old, Single, Primary School Student, Rural setting).

”

In another case, the participant was a student and after she informed the man responsible that she had missed her periods, the man brought her pills and forced her to swallow them. In two cases, the partners (one of whom was married) did not want to have another child and were given abortifacients under the pretense that they were painkillers, as the participants had complained of having the flu.

Reasons for keeping unintended pregnancies

In some situations, the girls and young women kept the unintended pregnancies because of their previous experience with abortion. As described by one participant:

“

I got the first pregnancy but 'nikatoa' (I removed it). Then I came and got the second one. I thought about the pain that I went through last time, I said just let me give birth. Wee! It was risky to lose blood. I even thought that I was going to die. It took me a long time to heal because I was bleeding too much. Now the guy told me to get rid of the second one. I told him I cannot. I then told my mother, then my mother told me "There is no problem, you just give birth." That guy now from that day we disagreed because he wanted me to remove it (pregnancy) and I refused. (18-year-old, Single, Unemployed, Rural setting).

”

Some participants claimed that fear of the authorities, especially the police, influenced their decision to not have an abortion.

It was common for girls and young women to say they "feared" being arrested because abortion is illegal in Kenya. However, there is little evidence of cases going through the full legal process. For example, one village elder explained how he would normally deal with abortion cases in his community:

“

Usually, I have my own investigators who, when they hear rumors, they come and tell me and I usually go and ask the family about it and most do not open up. But I remember one case the girl was pregnant and then the mother helped her abort and they put the child in the toilet, but the neighbors decided to report to me. So, when we went there, we talked to the family members and afterwards the neighbors helped with removing the child from the toilet, but it was already dead. I took the case to the assistant chief and then we went to the police. Sometimes I don't even wait for the assistant chief, I go straight to the police and tell the assistant chief to find me there. (Village Elder, Rural setting).

”

In summary, the decision-making process around terminating the study participants' pregnancies hinged on a variety of factors and was often complex. Table 3 showcases seven cases that highlight the complexity of the decisions around abortion and the multiplicity of factors involved. Often, the decision was based on a compilation of factors. Occasionally, the decision was not made by the girl herself but by other actors.

Table 3: Reasons for abortion

Age of girl	Nature of relations	Reason for abortion
17	Boyfriend. Close in age, dated for 6 years.	"I felt it would be hard for me to go back to school and I might even drop out."
22	Boyfriend. Close in age, dated for 3 years.	"The boy also wanted me to get an abortion." "I thought of how, being the first girl in my family to join high school, I had made a mistake." "I wasn't ready to keep the pregnancy since my boyfriend was not independent enough to support a family." "I wasn't willing to leave the chance to join college."
24	Married man. Dated for 6 months.	"He is a man with a wife. He switched off the phone after I told him about the pregnancy." "If I had given birth and taken the child to my parents, they do not have anything." "Because I was told that in nursing school, people don't go there pregnant."
23	Casual sex	"I am scared people will find out about the pregnancy, especially my mother." "Because I was in school." "I didn't have money." "It is someone I don't know."
21	Boyfriend. Dating for 1 year.	"The boy told me to remove it." "Furthermore, at home what would I say? Yet I live with my stepmother."
25	Husband	He said that the pregnancy was a present that he had given her, and it is these words that made her not have second thoughts about aborting it. So does it mean you did this out of anger?"..." Yes I did that to punish him because at first he was very happy and proud about the pregnancy and later started saying things unconsciously without considering my state and by me aborting I am sure that really hurt him."
20	Boyfriend. Close in age, dated for two months.	"Since he denied the pregnancy, his phone went off, I have never gotten in touch with him." "Looking at the situation at home, I am the only one fending for my grandmother. She lives there and she is very old. I could not give birth. How would I take care of my grandmother and a baby? That would be so hard."
23	Boyfriend. Partner was a former client (sex worker)	"I could not start taking care of a baby and I didn't have the money to do so. So, I chose to remove it. It wasn't even the first time I was pregnant. I have been pregnant before and I removed them."



III. Care / help-seeking pathways to abortion

“

...and he told me we should plan to meet his uncle, who is a traditional healer, so that he can help me. I went back home and afterwards we went to see his uncle. He gave me black powder (shubiri) that I was to boil and drink when it was cold. So, I came home, and I boiled it and drank it but nothing came out. I waited 2 days, but I didn't see anything, and I went back to tell him... (Mapenzi, 16-year-old, Single Primary School Student, Rural setting).

”

Once they decided to terminate their pregnancy, Mapenzi and the other adolescent girls and young women in this study had to seek out ways to do it. The abortion pathway started with the information women and their partners had on abortion (or could obtain) and the types of methods available.

Access to information

We found that girls and young women from the different parts of Kilifi County have varied access to information concerning abortion. The sources of information included the school environment, friends, the wider community, and local chemists. Information obtained in school often centered on the risks associated with abortion and the legal aspects. In very few cases, girls were taught in school about the safer forms of abortion offered in medical facilities.

Girls and young women also learned about abortion from informal conversations among community members. Information about abortion included stories about the risks involved, including people who died as a consequence. Community members also spoke about local authorities and chiefs arresting people suspected to have undergone and/or induced abortions, and the providers who made these services available.

In addition to general information about abortion complications, girls and young women also reported that they had specific information on methods to terminate a pregnancy before they found themselves in need of such service. The information regarding abortion in rural areas was mainly about traditional

methods, such as “majaji” – usually used for treatment of other diseases – and “shubiri” – which is a traditional drug that goes for about 10 to 20 shillings (~USD 0.10-0.20). Other participants reported on Aloe Vera and “mkilifi” (neem tree), which is boiled to a high concentration until it tastes very bitter and then drunk. The girls also spoke of using Coca Cola which is boiled and drunk, energy drinks, and highly concentrated juice to induce an abortion.

In urban areas, girls and young women knew about medicine from the local chemist that could be used for abortion. Some of the adolescent girls knew that one can take the drugs and then go to the hospital to be “cleaned” using a “metal rod”, a process which they described as a “painful experience”. (See Table 4 for examples of the prior knowledge of abortion that participating girls and young women had about methods, as well as their sources of information)

Once they got pregnant, girls and young women leveraged this prior knowledge to inform their care-seeking pathways. Participants who did not have any information, apart from that on the risks, decided to seek help in getting the right care to avoid the consequences they had heard about. Some knew about certain methods but considered them safe (see section on safety for more on the girls' perceptions of safety) or wanted to get additional information before making up their minds. Getting information about abortion was regarded as easy for some and difficult for others. The information-seeking process was made more difficult because of the secrecy and stigma regarding abortion, the threat of being arrested, and the fact that they are considered young and should therefore be naïve about sexual matters. Most girls mentioned friends as their top source of information. Some girls, like Kabibi (a 22-year-old student), would confide in close friends, preferably those having experience with abortion.

“

For me, I trusted it because my friend told me she had experience, I asked her for help. I also inquired from her how old her pregnancy was before aborting and she said it was a week old. I requested her to give me the drugs that she used and I knew it would suit me. (Kabibi, 22-year-old, Single, Student, Rural setting).

”

In some cases, girls and young women sought information from friends with whom they were not necessarily close, but were approached because of their history and experience with abortion, or their age and networks. The male partners who were involved in seeking information explained that they obtained it from their male friends who had experience with abortion or from their female partners who got the information from other sources, as a male partner said:

“

She (the girlfriend) got it from her friends. You know, genders are different; there are those friends you know have terminated a pregnancy before, so you just follow their advice. So, she was told so-and-so used a certain pill and that's when she gave me the feedback. (25-year-old male partner, Manual Worker, Urban setting).

”

In other situations, girls would consult their female relatives who would also help them procure medical abortion drugs and prepare traditional herbs. Finally, some girls and young women sought direct help and information from people in their networks, such as pharmacists/drug vendors or healthcare providers. Some girls, for instance, went to a chemist for a pregnancy test and, after the positive result, they asked for help in termination.

In most cases, and as a way of dealing with the stigma and preventing disclosure, when seeking information, girls and young women spoke in third person. For example, they would say a friend of theirs is pregnant and she wants to terminate the pregnancy.

Rationale guiding the choice of methods used

Our findings show that choosing the method to use is a complex process driven by various factors, including the pressure to terminate a pregnancy that threatens the social, economic, and family well-being of adolescent girls and young women. Despite the information in the community about the risks of abortion and the dangers surrounding it, many girls opted for the methods they had on hand or used the only method they knew about despite hearing about the bad experiences of others.

“

F: What made you choose that option of taking drugs?

P: That was the only one I knew. I did not know any other...

F: So when you decided to terminate the pregnancy, what did you know about abortion at that time?

P: Nothing, completely nothing, I only knew you could die, I knew completely nothing. So, when it happened to me (complications) I started asking people, but I didn't know. (23-year-old, Single, College Student, Urban setting).

”

The subsection below looks more deeply at the different reasons for choosing a particular method of abortion.

Availability and access to information and methods

Most girls and young women chose methods that were both easy to get and affordable. Some girls opted for the traditional methods, such as the use of herbs, because these were more accessible. This access manifests itself both in an economic and physical sense. For example, some girls opted to use traditional methods because they are easily found at home in the garden or bought in the local shops for as little as ten shillings (USD 0.1 \$), as compared to medical abortion drugs, which they considered expensive. Daisy, a 17-year-old girl, explained:

“

I: How much did the abortion cost you?

P: It didn't cost me anything.

I: Where did you get the tea leaves?

P: I borrowed the tea leaves from a neighbor.

(Daisy, 17-year-old, Primary School Student, Peri-urban setting).

”

Those who opted to use medical abortion drugs considered the option more accessible than surgical methods, both in terms of cost and access. Girls who used medical abortion drugs would commonly source them from the providers themselves in private facilities, pharmacies, or their relatives, partners, or friends with whom they shared the initial news of the pregnancy. To access the drugs, girls sometimes did not have to physically go to the pharmacy or the health facility, and usually a friend, partner or relative could procure the drugs on their behalf, thereby ensuring their anonymity is protected, as revealed in the quote below:

“

My cousin-sister is the one who helped me; she connected me with a friend, who then connected me with a doctor. Because the pregnancy was young, about one month, the doctor brought me medicine that I swallowed, and it came out. (25-year-old, Single, Hairdresser, Peri-urban setting).

”

The above quote also shows how a whole network, based on trust and acquaintance, is mobilized to discreetly access abortion. To preserve that social safety, some girls had to endure sexual abuse from providers when procuring abortion pills but went quiet about the abuse to protect their secrecy. One pharmacist admitted to sexually abusing emotionally and economically vulnerable girls who would seek services for medical abortion from him.

“

...I had a scandal, there was a time I was given a college girl who was very beautiful. She came to me as she was given my number. So, after all that, you know there are some [medications] you have to insert in the vagina and some you have to take them sublingual [orally], upon opening and unzipping down and all that, I erected and told her “You are beautiful, you deserve this before eliminating what needs to be eliminated”. So, I enjoyed sex and up to now I keep on enjoying the sex because of that time, it went successful, and I remember telling her that, you know what, ‘upon done sex and then I insert this, and four hours maximum everything will be down.’ And she believed that, and it happened like that. (Pharmacist, urban setting)

”

In addition to using the argument of the sexual act being part of the procedure to abuse girls seeking abortion, this provider reported that he would also exchange medical abortion drugs for sex when girls could not afford the cost of the medication. Concerns about anonymity clearly bring out the tension between the issue of social safety versus medical safety in the rationale for choosing a particular method, to the extent that it increases the vulnerability of young women to using “unsafe” methods and exposes them to abuse.

Social safety versus medical safety

Due to the risk of stigma and prosecution for procuring an abortion, girls and young women were more worried about people finding out about their pregnancy and abortion than about their physical safety. Some, for instance, knew about different methods of abortion and also had information about the “safety” of these methods, but in the end, they chose what could be called the “unsafe” option as it was more discrete and preserved what we can refer to as “social safety”. Using traditional methods, for example, was seen as something that does not raise any flags, since the preparation is done at home. For example, Ruth, a 17-year-old, high school student in an urban setting, took advantage of the multi-purpose nature of these herbs and when asked by her younger sister why she was boiling aloe vera, she said, “*I told her I had a flu, that is why I am boiling aloe vera.*” After boiling the aloe vera, she had a strong concentration of the liquid, which was about 250ml. She put that in a cup, and then steeped a small piece of shubiri in a cup of water. The shubiri was in their house and had been purchased to treat her younger brother.

The findings also show that many girls engaged in abortion attempts at night or in the evening so that other people in the household would not know of the abortion. Some of the young girls described their houses as being small, most often consisting of two rooms with walls made of mud and a roof of thatched grass; thus it was common for girls and young women to share a bedroom with other members of their family. This resulted in a lack of privacy for them, and sometimes resulted in girls and young women leaving home to terminate a pregnancy so as to protect their “secret”.

Although many of the study participants chose methods they considered discrete, most eventually ended up with complications that disclosed and publicized their abortions. Most girls who used medical abortion drugs or had their abortion done by providers in public and private health facilities had in mind the “medical safety” offered by such methods. Some girls in the study opted for medical abortion drugs because they had seen the drugs work successfully for other people. In Amani’s case, she used a combination of medical abortion and MVA. She says she had information about using traditional methods,

but she did not want to take a chance that the drugs could fail her and perhaps cause her complications in future:

“

I intended to terminate the pregnancy. I didn't have any other method, because I was told of a woman who sells herbs for abortion but I didn't want to guess and that is why I went where I was sure since he had helped most people with success. [...] I did not want my uterus to be damaged. (29-year-old, Single, Unemployed, Rural setting).

”

Unlike the case of Amani, Zawadi, a 25-year-old young woman living in an urban setting had a friend who proposed that she go to a private facility and have the abortion in a surgical way using MVA. However, she said she objected to it fearing that she might face some complications in the future if the procedure was not done properly. Instead, she opted to take medical abortion drugs. Sophy, on the other hand, knew about the possibility of getting a safe abortion from a hospital, but she lacked specific information on the types of methods used by local hospitals and the potential risks associated with them. Therefore, she fell back on traditional methods:

“

I did not want to go to hospital because I had not sat down with anyone to give me a hint of how they abort pregnancies at the hospital. I don't know what they use. So, when I heard that shubiri can work I thought, let me try it because I hadn't heard anyone else's experience of how they do it at the hospital. Whether they use drugs or something else...things like that. (Sophy, 22-year-old, Shop attendant, Rural setting).

”

In her case, using shubiri appeared safer, given that she had already heard about the experience of some other women with it. Moreover, while interviewed about their perceptions of the medical safety of the herbs/roots and other plants, some girls were of the view these methods were the safest for terminating a pregnancy because herbal medicine is used at home every day and therefore, they do not consider them harmful. They also reported that they never heard of anyone dying after taking herbal medications, and this alleviated many of their fears. As expressed by Sophy:

“

I didn't have too many worries because the little I got...the stories I heard...I never heard of anyone who died from taking shubiri when aborting. So even though the worry was there it wasn't too much. (Sophy, 22-year-old, Shop attendant, Rural setting).

”

Table 4 shows some of the participants' prior knowledge of abortion and how it influenced decisions about the methods used.

Table 4: Methods known versus methods used and sources of information

Age of girl	Rural/ Urban	Prior knowledge on abortion methods	Source of information	Abortion method advised during pregnancy	Sources of information (Actors)	Actual method(s) used
19	Urban	Abortion pills, surgical method "metals"	Biology class	Abortion pills	Friend	Abortion pills + MVA
23	Urban	Abortion pills	Friend	Abortion pills	Friend	Abortion pills + MVA
24	Urban	Underground abortion	A village girl (died of the abortion recently)	Surgical	Aunt	Surgical abortion
21	Urban	At the hospital (safe)	School	Traditional herbs	Partner	Traditional herbs
24	Urban	At the hospital, traditional herbs (fails), concentrated juice	Friends	Abortion pills, MVA	Aunt	Surgical (MVA)
17	Urban	Shubiri + Aloe Vera	Village girls	Abortion pills	Friend	Aloe vera
18	Rural	Bitter herbs (shubiri), coca cola, abortion pills	-	MVA (It is very painful)	Sister	Abortion pills
23	Rural	-	-	Misoprostol	Google	Abortion pills (misoprostol)

Study participants also reported on safety as being something subjective and uncertain, depending on the "body", "blood", or "luck". After undergoing a surgical or medical abortion, for example, some girls felt that the method they used should not be considered safe. They said that they could not advise their friends to use the same method they did, bearing in mind that the results may be different for everyone. Tatu, an 18-year-old unmarried young woman, had a surgical abortion. She considered it an unsafe method, and actually considered herself lucky to have even survived the ordeal, as revealed by the following quote:

“

I can't say it was a safe way because everyone has their luck. The plan of living, that way, it's a blessing already. I can't say that thing is fine, I can't say that. It's not good at all. I can't advise anyone to do that thing. I can't again. (18-year-old, Single, Job Agent, Rural setting).

”

Similarly, 20-year-old Lulu, who successfully used shubiri to terminate her pregnancy, indicated that she could not term what she used as “safe” because in her experience, everyone has a different outcome, and may go right or wrong for other people:

“

I can't say that it is a safe method because I may not know. For some, they may do the same thing and things go wrong. I can't tell my friend to do the same thing because with that method you may almost escape death. (Lulu, 20-year-old, Single, Rural setting).

”

Using multiple methods

We found that the uncertainty around the effectiveness and safety of different abortion methods, coupled with the lack of information and resources, may push some young women and girls to use multiple methods. In some cases, multiple methods were used if the first attempt failed, or when the dosage was considered insufficient. In 29-year-old Amani's case, the provider initially proposed a surgical abortion, but the money Amani had was not sufficient so she opted for a medical abortion. Unfortunately, after two attempts using different drugs, this method did not work. This pushed Amani and her family to look for more money and another provider who performed a MVA, which also failed. That provider finally gave her MA drugs as the fourth and final attempt, which was successful. As Amani's sister explained:

“

I took her to the first doctor in a private facility where I had been directed by my friend, when we went to the doctor, he said he couldn't use the suction method because the money we had wasn't enough. He charges four thousand shillings, and we only had two thousand, five hundred shillings. He opted to give us the drug, of which he said it would be painful, but the process would be complete. (...) She took the drug, but nothing happened and after a few days I called the doctor and explained that nothing happened. He requested that we should go back so that he could give other drugs or we look for money so he could do the suction method, but we didn't have the money. So, we opted for different ways. We got a different doctor in a private facility. He asked for three thousand shillings, we looked for money and gave him. He did the suction method but there was less blood. The doctor said the process might be complete or incomplete, but we should give it like two days. When she went home nothing came out. I called the doctor. She requested us to go back. When she was asked how she was feeling she said she still feels pregnant. He told us that the abortion was incomplete and suggested we should use the drugs so we are sure. When she used the drugs as prescribed, the process took place. (Amani's sister, 38-year-old, Rural setting).

”

In total, Amani and her family spent KES 9,000 (~USD 90) and had to go through four attempts. In most cases, limited finances push girls and young women to first start with affordable methods (i.e., unspecified drugs, plants and herbs, untrained providers with cheap options), which in many cases fail, forcing them to try other methods.

Girls and young women using traditional methods also have to make multiple attempts, as highlighted by Sophy:

“

I tried jaji (jasmine) first, but it wasn't successful. Then second, I boiled mkilifi. I used the leaves and left-over peels when boiling. I boiled it two times. Day One I boiled it and felt my stomach aching for a while before it stopped. Day Two I tried again and added a lot more peels to make it bitter. I drank it but I didn't see any success. Then I remembered there is shubiri. So, I thought, where would I get it, but then I remembered my sister...there is a cousin who has a chest problem. I went to her place, took it, and boiled it that day. That's when I felt my stomach aching and I knew it was ready. (Sophy, 22-year-old, Shop attendant, Rural setting).

”

Table 5 shows the multiple abortion methods used by a sample of participants in more detail.

Table 5: Multiple and mixed abortion methods used by some of the participants

Age	Rural/Urban	Actual method(s) used
17	Urban	Jaji + Mkilifi
22	Rural	Mjaji (herbal tree) + mwarubaini (neem tree) + shubiri
15	Rural	Shubili and mwarubaini (neem tree)
29	Rural	Abortion pills (4 times) + MVA
18	Urban	Abortion pills taken twice
24	Urban	Mix of traditional herbs and tea leaves
21	Urban	Shubiri + Abortion pills + MVA
22	Urban	Aloe vera + Shubiri + Abortion pill
16	Urban	Abortion pills + MVA

(Shubili/ shubiri - traditional medicine used for various diseases such as flu)

Inducing abortion: feelings and emotions

“

It was difficult, I didn't have money so I had fear of what could happen. My boyfriend as well had to wait until the end of the month to get paid, my sister too didn't have money, I had a headache due to lack of money. I tried my best, the first doctor needed three thousand shillings, I got the money and gave the doctor, but the process didn't take place (the drugs did not work), I was given an option of a different doctor who was far, I had to use a motorbike to reach there, I explained to the doctor, and he asked for one thousand, five hundred shillings. I didn't have the money at that time, so I promised to be there the next day. When I went, he gave me the drugs to insert while at home, I tried but I wasn't able to use them. I had to call him. I went to the hospital so that he could insert it for me, then came back home, waited with no success. I had to call again, he told me to add money. I had to seek other ways. I went to a dispensary and explained to him. He gave me his number and promised to offer help. When I called him, he said he was far away and couldn't help [...]. We made plans for the day the abortion was to happen. During the process there was less blood. She doubted whether the process was complete. She gave me painkillers and I went home. (...) I called the doctor and explained to her. She told me to go back to the hospital and when there she said she knew it was incomplete since there was less blood since my vagina passage was narrow. She said I have to add one thousand, five hundred shillings more so she could get the drugs from Mombasa. I was ready to get money from people to refund later. I gave her the money and she brought the drugs. She explained how I should use the drug. I took one at a time; it didn't take long after taking the second pill and I had a stomach ache. I had to persevere alone since I didn't want my mother to know. I cried during the process. I share my bed with a young one who doesn't know anything, and my mother is in a different room. I was alone and I took the phone and texted my sister who has rented just near our home and told her the process was complete and my stomach was aching. She encouraged me to persevere, since when my mother would find out we were all in trouble. I would be named a murderer, so just persevere till the blood started to come out. (Amani, 29-year-old, Unemployed, Single, Rural setting).

”

Emotions

As highlighted in Amani's case, all girls described their abortion process as a difficult journey imbued with stress, loneliness, fear, guilt, and pain. Amani, for instance, did not have money to pay for the abortion services, and had to borrow the money. And given multiple failed attempts, she had to borrow money several times.

Other girls and young women were anxious about experiencing a failed abortion. Many also worried about complications or about death, and about having to seek help if complications arose and disclosing to others that they were in the process of an abortion:

“

I was worried. I had heard stories of some people who terminated their pregnancies but when they went to get tested the pregnancy was still there. So that's the worry I had. (Terry, 23-year-old Sex Worker, Single, Urban setting).

”

“

I was so worried because in that week there was a girl who tried to abort and died. I was afraid. What if I abort and also die, something like that? (Nina, 22-year-old Stay at home, Single, Rural setting).

”

Experiencing pain

Study participants used various abortion methods and the pain they experienced also varied. Some described the pain as “cutting” through the “stomach”, while others described it as worse than the pain experienced during childbirth. Describing her experience, Brenda noted:

“

It was like cramps during periods, but it was more painful. I got to a point where I couldn't take the pain. So, my auntie was confused. She asked what the problem was, and my sister explained it to her. She gave me Panadol and sponged my stomach with hot water. She said we should wait for morning so that she can take me to the hospital. (Brenda, 18-year-old High School Student, Rural setting).

”

Most girls also reported heavy blood loss that made them fear they would die. The study participants managed their pain in different ways. Like in Brenda's case above, hot water was used for massage or bathing, while others took pain relievers such as Panadol to reduce the pain.



IV. Post-abortion care: When things get out of control

Once Pendo's³ decision was made, her abortion was induced by a provider who inserted a drug into her vagina, and told her that the medicine would begin to work after six hours, during which she would experience some stomach pains, bleeding, and finally the product of conception would be released. The process started that evening with a lot of pain and bleeding, which forced her to go back to the provider (who requested her to be patient and bear it) and disclose the situation to her relatives, including her mother, sister, and aunt. Together, they quickly took actions to deal with the situation:

“

When it got to morning, I saw her [mother] boiling some water and putting it in the bathroom for me. She went and bought coconut oil and told me to go to the bathroom. When I got there, she started massaging me. (...) She massaged my stomach, my head with hot water. Just like when someone...has given birth.

”

She then bled continuously for two weeks. Afterwards, her cousin came and borrowed her skirt to wear on a date with her boyfriend. She returned the skirt to her and Pendo wore it the next day without washing it. That evening her stomach started swelling and she was not passing stool. She was taken to a private hospital, where she was diagnosed to have “a lot of water” in her “stomach”. Subsequently, she was taken to the district hospital where she was told that she had accumulated blood in her womb and needed to undergo an MVA. Despite the procedure, she still did not pass any stool, so the family decided to take her back home. There, her aunt insisted that she should not stay home as she had no “Giriama” protection (a piece of cloth worn as an amulet on the arm to keep away the evil eye), and family members at home were not good (due to witchcraft). She was taken to a pastor and a traditional healer (her father's sister) since the family thought her situation was spiritual.

³Pendo, is a 19-year-old girl whose case was described in the introduction to this report

“

I was taken to the pastor but let's say he did not succeed. He took water and coconut oil and mixed it, then prayed for me with that water. Then he took the bible and waved around me seven times. I was taken away to my aunt's (mother's elder sister), and my aunt came and conducted traditional rituals for me. She took some leaves and mixed them with water. She poured them on me and took a chicken and waved it around me seven times. (...) Then I was given traditional medicine- some to lick, and the remaining in water...She would continue preparing the medicine for me until the cloth (Giriama protection amulet) was loosening by itself. After I started passing stool, I stayed there all week then I was sent home.

”

The aunt identified the illness as “vithiyo”, which affected her due to the sharing of clothes. Although she did not believe it was caused by the abortion, her mother believed that she was suffering from this because she had an abortion, which is an evil thing. Thus, the family had to perform some rituals so as to wade off the evil spirit of the illness, or else they (Pendo and her family) would die.

Pendo's case is indicative of how girls and their relatives sometimes interpret and give meaning to the complications they experience and how they handle it. The case also mirrors the care-seeking behaviors of most of the participants in our study, including the actors involved and the type of care sought, whereby girls would seek either care in health facilities, or traditional and/or religious interventions to deal with the ill health.

Interpretation of complications and decision-making to seek care

Once their abortion was induced, women usually expected (or were told to expect) some bleeding and pain. Therefore, some of them did not perceive bleeding as a sign of a complication. In most cases, bleeding and pain started to alarm the young women when it was excessive or prolonged. The young women and girls in our study described excessive bleeding in terms of the number of menstrual pads used in a day, blood “pouring”, or as bleeding accompanied by dizziness. This is explained by two participants:

“

I bled for two weeks. I was changing the pads so many times, because even when I would put on a pad I would need to add another one because it was coming out alot. Yes, I was feeling dizzy. (20-year-old, Married, Unemployed, Rural setting).

”

“

Weuh! Blood was flowing like water. Blood was just pouring, I did not even use a pad, I went to the sitting room, I stood there and it was pouring down like water, I then cleaned the floor. I thought about everything. I knew I was going to die. There is nothing I did not talk to God about. (19-year-old High School Student, Urban setting).

”

In some situations, the study participants would buy medicine at the pharmacy and wait for the bleeding to stop. Others reached out to the provider who induced the abortion to seek advice, or relatives, or friends. Several noted that in such instances, it was not always possible to reach the provider, or the provider advised them to seek help in a health facility.

The type of care the girls and young women resorted to depended on the interpretation given to the complication. When seen as a medical condition related to abortion, they would seek care in public or private facilities to get their “womb washed”. Other girls and their families, like in Pendo's case, believed that the complications resulted from breaking social norms that prohibit inappropriate sexual interactions within the extended family setup. In those cases, ‘washing the womb’ was not sufficient, and the girl had

to go through traditional cleansing rituals before recovering. In other cases, girls would interpret these complications as punishment from God because they committed the “sin of killing a human being”. In such cases, girls would delay care-seeking at the facility, and instead visit pastors in hope of both physical and spiritual healing. In some rare cases, they would avoid seeking any help at all, partly due to stigma, and resort to prayers, as in the case of Saumu below:

“

P: I didn't want to [seek help] because if I went to, for example, the government hospital, they would have known what the problem was and I didn't want that.

I: So you endured the pain?

P: Yes, I endured praying to God. God let there be nothing else that will happen.

I: So the reason for you not seeking help is because you didn't want...

P:... because if I went to a government hospital they would want to know who did that act. So I didn't want; I said let me stay that way. (21-year-old, Single, Waitress, Peri-urban setting).

”

The fear of stigma often led to delayed care-seeking. Some girls and young women, such as Saumu, would bear the pain or self-medicate using painkillers or herbal remedies. Others would delay care until the pain was unbearable, or until other people discover the complication. Indeed, when the complications became very serious, others would notice and take them for treatment:

“

(...) I noticed she was looking pale and weak, when I asked her she started crying and she told me that she thought that she had disappointed me. She even fainted and we had to take her to the hospital. (Grandfather to 20-year-old, Single, Waitress, Rural setting).

”

“

Nobody knew. We were all surprised why she fell and she was bleeding. We were surprised and rushed her to the hospital and she told us after she regained consciousness in the hospital. I didn't even want to quarrel with her. I just kept quiet. My parents were very stressed, especially my dad. He was very stressed. (Sister to 23-year-old, Married, Businesswoman, Rural setting).

”

In the study, 21 out of 54 participants experienced complications that led them to seek post-abortion care in medical facilities. It is important to note that the PAC experience observed and analyzed in the section below are all drawn from our observations and interviews from public health facilities.

Diagnosis of the type of complications

Once a patient was admitted, one of the key steps in the care process was the diagnosis of the type of complications they were experiencing (i.e., incomplete or missed abortion). The approach to diagnosis depended on the facility level and their location. At referral-level facilities, providers reported that they would first perform a speculum examination. If the cervix was open, the patients would be sent for a scan and a pregnancy test.

“

After that, the bleeding didn't stop. I came to (name of facility withheld), I explained to the doctor, he sent me for a scan. I called my boyfriend, he came to the hospital and after the scan, I was told to come to the room where I found you. (18-year-old, Single, Unemployed, Rural setting).

”

In the case of a negative pregnancy test, they would check the scan to confirm for other diagnoses, such as fibroids. In the case of a positive pregnancy test, they would diagnose the abortion as incomplete, or as a missed abortion, and then perform an MVA.

Obtaining an ultrasound scan was challenging for some patients, especially those who lacked money to pay for the scan or those living in rural areas. In both cases, it would take them time to have the test done, either because they had to look for money, and/or because they had to travel to bigger facilities. This delayed the care process, especially for cases requiring urgent medical attention. Therefore, some providers in rural facilities, where the ultrasound scanning services were not available and the population mostly poor, reported they would assess the situation using a physical examination. According to them, a physical exam, together with a pregnancy test, helped them to properly diagnose the case and identify urgent cases.

The diagnosis also included finding out whether the abortion was induced or spontaneous. According to providers, it was difficult to differentiate between a spontaneous and an induced abortion. While the providers usually reported that they had performed a number of assessment tests, most of the time they depended on the patients' openness and willingness to talk:

“

It is very hard to know; we usually just say incomplete abortion. It is hard to know unless you grill the patient then they tell you they aborted. But most usually say they started bleeding, they won't say they tried to abort. Especially young women they won't open up but older women who were married will tell you that they didn't want the pregnancy. (Provider, Public Facility, Rural setting).

”

“Grilling” the patient appears as one of the strategies to know whether the abortion was induced or spontaneous. Some would rely on the age and marital status of a patient to make their diagnosis. Findings show that there was a perception among providers that older and married women usually came in with spontaneous abortions, while young unmarried women usually came with induced abortions. If a woman seeks PAC services accompanied by her husband, most providers typically assume that it is a spontaneous abortion.

“

We look at the age and their marital status. Many of these people you will just see when they come in. The younger ones will say they are just bleeding. They come in panicking because they see they are bleeding and they have done something at home. So you can see when someone is bleeding and panicking. Many times when you find a grown woman with a husband and other children, that is most likely a spontaneous abortion. (Provider, Public Facility, Urban setting).

”

Additionally, some providers reported that the state of the cervix can also be used to discern whether the abortion was induced or spontaneous. For an induced abortion, according to the provider, the cervix of the girl is usually open or punctured, indicating that someone tried to interfere with the pregnancy.

Provider-patients interaction during PAC

Waiting time

Findings show that the waiting period differed from one patient to another. Some participants did not wait long before receiving care, reporting that they were attended to as soon as they arrived at the facility. Many others had to wait up to an hour for service. In some cases, like Jeane's, patients had to wait the entire night before getting the MVA performed:

“

I could not sleep at night, I was in pain and I was still bleeding. That is when I was brought here at 2 am. The doctor gave me some medicine, so I have been waiting in the casualty. The doctor said I should wait for her here. I don't know where she is. It is now around 1pm. (Jeane, 19-year-old, Single, High School Student, Rural setting).

”

In some facilities the delay in care occurred because the facility had only one trained provider who had to attend to multiple patients, while others had newly trained providers who were not confident in offering services. In other facilities, the available providers indicated that they did not provide PAC services:

“

I faced difficulty because I stayed there the whole day knowing that I would get 'cleaned' but I didn't. I can say that I followed four doctors. Whoever I followed told me that she wasn't able, she isn't involved with such things. (21-year-old, Married, Housewife, Rural setting).

”

Issues related to equipment also explained some delayed care. The study shows that some facilities, especially the high volume ones, had trained staff who were present when the PAC patients were admitted, but they could not perform the MVA because they lacked the equipment (the kit) to do so. Providers explained that the kits would be hidden by other staff who would use them for their private businesses or 'steal' the cannulas and use them in private clinics. In other cases, the equipment was privately owned by a provider who was not always present at the facility. In such cases, patients would either be sent away or requested to wait for the person owning the kit to come back:

“

Later nurse X came in and said hello. She then told me that they had two cases yesterday but they had to refer the cases because Dr. X was not around and there was no one to perform the MVA as they do not have an MVA kit. (Observation notes, Public facility, Urban setting).

”

Some facilities had only one functional MVA kit, and providers had to sterilize the equipment between patients, leading to delays. In some instances, space was limited and the PAC patients had to wait because the room was being used for other purposes, such as delivery.

Communication with patients

According to some providers, when patients arrive at the facility, they would first explain to them the types of methods available for PAC services, which is usually either the MA (drugs) or the MVA procedure. Providers also noted that they would explain the advantages and disadvantages of each method, and then let the patient decide on the most appropriate method from their perspective. Sometimes the patients were given a chance to ask questions or share any worries they may have before the procedure is done. However, from our observations and from the patients' reported experiences, we found that

communicating information to patients was not systematic. Some patients were just told “mimba imeharibika” (the pregnancy was spoiled) and requested to go to a room for the evacuation. Some of them were also not given the option to choose between either MA or MVA.

“

After a while there was an empty bed in the casualty and we went in and the lady removed her panty. She asked me where she would place them and I told her to place them under her head. Nurse X explained the procedure and said “I am going to perform MVA. That is a process of cleaning, it is a little bit painful but it's about five to ten minutes if you cooperate. You will endure then you will be fine.” He asked her if she had any questions and she said no. He started the procedure. (Observation notes, Public facility, Rural setting).

”

Some providers acknowledged that most of the time, they do not offer patients this choice and the type of method offered depended on whether it was an incomplete abortion, missed abortion, or the patient's condition. The use of MVA during PAC was particularly high in the study, and only two participants had a MA done. Moreover, in both these cases, the MA protocol was used after unsuccessfully using the MVA procedure.

Although most patients reported friendly providers, a few patients were talked to rudely when receiving the PAC services. Most of those patients were single and had induced their abortion, and they thought the provider's attitude was related to the fact that they interrupted their pregnancy. In the case of Irene, she was shouted at by a nurse during the procedure and told to cooperate or else she would be left alone to go and pay for the service in a private facility.

“

You remember how I was crying. I was screaming and the other doctor was shouting at me, telling me I should stay still since they were offering the service to me for free and if they stop I would have to go to a private hospital and pay a lot of money. That doctor isn't compassionate. (Irene, 23-year-old, Married, Businesswoman, Rural setting).

”

A similar case of abuse was recorded for a survivor of SGBV that was brought in:

“

The nurse was slapping her and the girl was screaming and crying and did not want to open her legs and X literally held her thighs apart and asked Dr. X to do the swab. When Dr. X inserted the swab kit it came out with blood and he asked the girl if she was on her period and the girl said yes. X then slapped the girl again and asked her “why didn't you tell me that you are on your periods. I have been with you since morning and you didn't mention it”. (Observation notes, Public facility, Rural setting).

”

Privacy and confidentiality

Findings show that privacy is a key factor in seeking PAC services, given the taboo and stigma surrounding the issue. However, for patients treated in public facilities, privacy is limited; some of the PAC services, such as the MVA, are provided in the casualty or delivery rooms where there are other patients. One participant commented about the MVA room saying, “I didn't like it. There is no privacy, everyone sees you.” (18-year-old, Single, Unemployed, Rural setting).

In some facilities however, MVAs were done in a specific room set aside for the procedure. In general, participants were worried about privacy during the procedure. Because of this concern, many girls and young women tried not to scream or cry because they were afraid that people would ask about what was going on inside the room where they were being treated.

Pain and pain management during PAC

While most PAC patients from the study were treated using MVA, findings indicate that MVA procedures were particularly painful and patients were often heard screaming throughout the hospital. In most cases, participants were not given pain management medication, as in the case of Tatu:

“

Heh! I was seeing that I'm going to just die. I was feeling a lot of pain because there is no numbing injection. You feel the thing being pulled. That is, you feel it completely. It is not like giving birth at all. Giving birth is easier. (Tatu, 18-year-old, Single, Unemployed, Rural setting).

”

According to providers, the decision to administer pain management medication was made on a case-by-case basis, and depended on the patients letting those caring for them know how severe their pain was:

“

Ah she wasn't given any medicine. She was just given a place to sleep and wait. We don't usually inject pain medicines but it depends on the situation because you will find some are in so much pain so you inject them but the small small ones you just do the procedure; they aren't in pain. (Observation notes, Public facility, Rural setting).

”

We observed at the facility that sometimes patients would be given pain management medications, and sometimes not. Other factors, however, such as the skills of the provider and the state of the equipment, also limited effective pain management. For example, in some instances, there was only one anesthetist in the facility while in others, pain stemmed from the providers' skills:

“

Dr. X gave her a pain injection and started the procedure. He first inserted the speculum and he then inserted a cannula. He asked me to use my phone torch and he started performing the procedure and the girl was in a lot of pain and it was challenging for her to remain still and relaxed. I will say this particular MVA procedure was challenging as Dr. X kept on saying that he can't really access the cervix opening that leads to the uterus. It was bloody and he had to keep cleaning the area using gauze. The girl was screaming every time Dr. X tried to insert the cannula in the cervix. Dr. X was using the new MVA kit and it seemed that he wasn't comfortable with the green colored cannula. He said, "I wish I had brought my kit, this cannula is not working well. (Observation notes, Public facility, Peri-urban setting).

”

Intense pain was also blamed on poor MVA equipment. In most of the health facilities, we observed that the MVA kits were either broken, faulty or parts were missing. Some of the faulty kits would be missing the K-Y lubricant needed, and condoms would be used in its place. In cases where the kit was not complete, sometimes parts would be borrowed from other departments, such as the maternity unit. If not, some providers would simply refer patients to other facilities. Others, however, would still manage to offer care, but at the cost of longer and more painful procedures.

Costs of PAC

Although PAC services are expected to be free in public health facilities, this was not the case in three of the four involved in our study. During our observations in those facilities, we noted that there was no definitive price for PAC services. The cost depended on the provider and patients could negotiate the price. In cases where the patient could not afford the care, they sought services elsewhere or waited and returned when they had adequate funding, as in the case of Khadija, who went for PAC at a public facility:

“

When we arrived, I explained to the doctor my situation and was told to pay KES. 1,500 [~USD 15] so that I could be cleaned. We did not have the money so I had a scan taken and we went home to get the money. We stayed one week and then when we had enough money we went back to the hospital on Monday. (20-year-old, Married, Housewife, Rural setting).

”

In the referral-level facility, the patients would be admitted as they waited for the PAC services and thus ended up paying an average of KES 4,000 (~USD 40) for the bed and medications offered. For some girls, this price was too high and in the case of Mishi, who was admitted into a public facility, her inability to pay the bill resulted in her being detained in the hospital for two weeks. She explained:

“

I was supposed to be discharged the same day (I was cleaned) but I didn't have the money. They said I should pay KES 4,500 [~USD 45] and I called the boy and he said he is looking for the money. So I continued staying there and the boy borrowed some money at work. By the time he got the money it was already 2 weeks. He came and he was told it was KES 7,000 [~USD 70] but he had KES 5,000 [~USD 50]. He talked to them and they accepted, I was discharged and I went home. (19-year-old, Single, Bar Waitress, Rural setting).

”

We also found that charges for PAC services varied by the time of day that the patient goes to the facility. In most instances, those who sought services at night in public facilities would have to pay for services, while those who sought services in these same facilities during the day might not be charged. The cost of services also depended on the provider, with some charging for them and others not. Patients also incurred additional costs if a required test or procedure was not available in the facility they attended. For example, patients in three of the four public hospitals would usually be sent for a scan that would cost them about KES 500 (~USD 5). If the necessary equipment was not available, for whatever reason, they would be forced to go to a private facility, which usually cost much more.

Post-abortion contraceptive counseling

After receiving PAC services, patients would often be provided with post-abortion counseling, particularly advice on family planning. They would be informed about the different types of family planning available, associated side effects, and the best methods for them. The patients would then choose the type of method they preferred and it would be offered to them. In one of the facilities, we observed the short-term methods of family planning being offered in the same room where the PAC services were provided. In other facilities, family planning counseling services would be offered in other sections of the hospital, such as the family planning clinic that was some distance from where the PAC services were provided.

“

So in terms of choice of family planning, we usually educate them. We tell them the type of contraception that we have. We explain the methods. So, it is up to them to make an informed decision and decide which kind of family planning they want to use. Since we discharge them through the MCH for family planning, we usually give a return date for another injection or contraception depending on the type of contraception she chose. (Provider, Public facility, Rural setting).

”

While contraceptive counseling in some of the facilities was given immediately after the MVA, in some instances, patients were not given family planning counseling immediately but were instead scheduled for follow-up visits, two weeks after the PAC services. Unfortunately, we noted, and this was confirmed by providers, that most of those patients do not come back, creating a missed opportunity. Some providers also reported that they are sometimes overwhelmed and forget (or are unable) to offer contraceptive

counseling, while others simply did not know that family planning was part of the PAC package. In one hospital, before attending a PAC training facilitated by NGOs, the provider did not know that family planning was supposed to be offered concurrently with PAC services.

Not all the girls and young women who received contraceptive counseling decided to use family planning. Some declined all of the methods offered, and stated that they could use abstinence or the withdrawal method. Others rejected the offered family planning methods due to the side effects they experienced with them in the past, such as recurrent bleeding or headaches. In some instances of spontaneous abortions, the women declined the family planning because they wanted to try to have other children immediately. In one case, the patient said she had to consult the husband, as in the Giriama community, she could not decide on such serious matters as family planning without consulting her husband. And in another unique case, due to the pain of the MVA procedure, the participant decided to have sterilization so that she would never have children or have to go through such pain again. Some of the girls and young women who declined family planning after their PAC services ended up pregnant a few months later. Kiri and Tunda, for example, rejected family planning and became pregnant. Both decided to keep the pregnancies. Tunda was initially shocked after finding out that she was pregnant again, and she had second thoughts about keeping the pregnancy because her relationship with her partner had been difficult ever since she shared the news of her pregnancy with him. She eventually decided to keep the pregnancy in the hopes that her relationship with her partner would improve. Kiri was initially terrified when she found out about being pregnant again, given that her last experience with abortion did not go well. She also expressed some feelings of regret and believed that her new pregnancy might be a punishment for aborting. Her decision to keep the pregnancy was easier this time because her boyfriend planned to take care of her and her child.

Discussion

Determinants of unintended pregnancies

Our findings highlight that a majority of the girls and young women in this study, both in rural and urban areas, live in precarious economic conditions. This was responsible for driving some girls out of school and into the workforce at an early age. Because of the limited income generated by these jobs, young women were left with little choice but to engage in transactional sex to sustain themselves or their families. These findings differ from those by Ssewanyana et al., (2018), who found that social environment factors, such as access to quality health care services and information, social events, and social media, play a bigger role compared to household-level factors such as family poverty, in increasing the sexually risky behavior among girls and young women in Kilifi. Thanks to the long immersion in the targeted community, combined with participant observation and interviews with various actors, we found that the factors highlighted by these authors were more like aggravating factors than primary causes of risky behavior. Specifically, while girls and young women live in precarious conditions, they are also exposed to conflicting information in terms of sexual practices and risk prevention. Parents emphasize abstinence, while health providers and others emphasize contraceptive use. Girls and young women, therefore, face a dilemma when it comes to making decisions about contraceptive use, which translates into low contraceptive uptake among the study population and increases their vulnerability to unintended pregnancies.

We found out that contraceptive use among adolescent and unmarried women was highly stigmatized, as it would indicate engagement in premarital sexual relationships. Girls and young women, therefore, fear to be seen at health facilities or pharmacies obtaining family planning methods. The stigma encountered with providers, for instance, translated into them withholding information or insulting girls, which drove away some of those who were seeking contraceptives services. Hakasson et al., (2018) explain these moral-based and social-based attitudes as providers viewing themselves as an extension of their community, and therefore as carriers of these societal norms. Furthermore, many girls also reported side effects and their partners' influence. Numerous studies have cited fear of side effects, in particular fear of infertility, and actual side effects as key barriers to using modern contraceptives (Ochako et al., 2015). The fear of infertility plays out particularly among women of childbearing age, as fertility appeared to be key to women's identity and the foundation for most marriages (Sedlander et al., 2018). Therefore, beliefs that contraceptives could "block the uterus", "spoil one's reproductive system," and "make the womb weak", were found to be crucial in the decision-making regarding whether to use them (Sedlander et al., 2018).

With regard to male influence, the majority of girls said that partners disapproved of the use of contraceptives. Other studies have focused on the influence of men on contraceptive use and documented that misconceptions among them about contraceptives cause negative feelings towards their use (Kriel et al., 2019). This in turn greatly reduces the chances of contraceptives becoming acceptable. This raises the urgent need for addressing these fears in interventions targeting adolescent girls and young women SRHR, as they are spread across generations and prevent the use of contraception. In this study, some participants also declined using contraceptives, saying "why should they plan a family that they do not have." This brings up the question of whether the term "family planning" is suitable for programs targeting young people while communicating about contraceptives.

Together, the low uptake of contraceptives or the discontinuation of their use, and the cultural and socioeconomic determinants increase the vulnerability of girls and young women to unintended pregnancies and, subsequently, abortion. The experiences of adolescent girls and young women with unintended pregnancies are therefore embedded in the already challenging life situations faced by adolescents girls and young women.

Decision-making for abortion

In terms of decision-making for abortion, our study shows that when girls and young women initially learn they are pregnant, they experience a range of emotions including fear, distress, and depression. These emotions stem from them not feeling 'ready' to be a parent, the potential consequences of the pregnancy on their future, fears about their parents' reaction (including physical abuse or being forced to get married), and a desire to avoid stigma. Therefore, the decision-making process on whether to continue with the unintended pregnancy or to terminate the pregnancy is an emotional, complex and non-linear process. For many, the decision hinged strongly on their partner's reaction and, on occasions where other people (including partners) were involved in the decision making, their views about the pregnancy and their advice influenced the course of the decision (Van der Sijpt, 2014). The eventual decision-making was a complex process reflecting the dilemma where girls needed to choose the lesser evil between having to face the consequences of the unintended pregnancy or the consequences of abortion (stigma and prosecution, risk of death or infertility). Similarly, an ethnographic study looking into reasons why women contemplate abortion in Burkina Faso found the decision-making process to be quite complex with intense periods of negotiation rather than linear (Ouedraogo, Senderowicz and Ngbichi, 2020). Our study also revealed the compounding nature of the factors driving the decision where, for instance, girls contemplating abortion because they feared the stigma of unplanned pregnancy, get comforted in their decision especially after the partner denied the pregnancy.

Care-seeking pathways and barriers to safe abortion

This research provides insights into the barriers and gaps in access to information regarding methods of abortion and the availability of safe services. The negative risk of death/infertility and the social stigma surrounding abortion are the main messages that circulate in the media, schools, churches and the community.

O'Donnell and colleagues' help-seeking framework is useful in understanding women's care-seeking pathways (2018). The authors posit that negative stereotypes regarding abortion, coupled by limited access to information and medical facilities that offer the services, make pregnancy terminations appear unacceptable, and abortion services unattainable, therefore a "problem" for women seeking to terminate a pregnancy. Therefore, they would seek "help" to solve their "problem", hence compromising the type of information and the quality of care they are likely to receive (O'Donnell et. al., 2018). This framework relates with the current study findings, especially for our participants from rural areas where there was a scarcity of information and services to terminate a pregnancy. Information given to the participants in these areas was regarded as "help" to end the pregnancy, as compared to those who knew particular methods that they wanted to use and just needed access to it. This portends doom to anyone seeking abortion services such that in the rural areas they end up seeking "help" rather than seeking "care"; as they needed guidance, information on the methods, and support in accessing the methods (including financial support). This help-seeking pathway does not directly lead to a medical facility to seek assistance but will go through various stages depending on the information held by the various actors involved.

Once they managed to get the information about the various methods, girls and young women made their choices on which methods to use based on the perceived safety and accessibility of the different options. We found out that most girls gave great priority to social safety, which was about getting the method and using it discreetly. In general, "traditional" (i.e., herbal) methods were perceived as safe, because they provided the "social safety" that was very important for girls and young women. Traditional

methods could be found and prepared at home as most herbal methods were also used in treating regular illnesses (though in smaller, less potent quantities). On the contrary, seeking help in a pharmacy or a clinic was seen as something compromising to social safety, as it would include disclosure of their condition to others, and potentially being observed by community members in the process. Jones and Kooistra (2018) found out that anti-abortion harassment from providers influenced the type of care sought by young girls. This is consistent with our study's findings that the anti-abortion sentiments of providers limited information-seeking in formal medical facilities, except for PAC after complications arise (when girls felt they could not avoid it).

While some girls could not choose medical and surgical methods because they lacked information and resources to afford them, other participants had concerns about their medical safety. Because of deadly abortion stories, they perceived surgical abortion as unsafe, and thought that it would lead to complications. Most of them could not discern the difference between the methods used by trained providers using medical abortion drugs or MVA, compared to services provided by quack doctors using unsafe procedures such as curetage. Therefore, due to these perceptions of the invasive nature of the procedures used by healthcare providers and a lack of information on safe methods that health facilities could provide, many girls opted for other methods. Coast & Murray (2016) found out that judgments about the risks of abortion are influenced by the stigma attached to abortion in the community and the guilt and shame associated with it. The unacceptability of abortion in the community gives rise to the idea that all methods are unsafe and cannot be used. This creates the perception that those who "survive" an abortion experience are just "lucky". These findings suggest that there is a need to rethink the concept of safety with regard to abortion methods and how distinctions are made differently by women and girls compared to SRHR programmes which can inform the communication about abortion methods. It also speaks to the importance of discretion while offering abortion services in order to protect women's social safety.

Results show that the choice between the methods is not as clear-cut as we may think. It appeared as if girls and young women bounce between methods depending on effectiveness or the time required for the method to work. These findings suggest that initially, some women choose unsafe methods of abortion because they are the cheapest. However, due to the multiple attempts needed to terminate the pregnancy, they end up paying more and risking their life. These findings echo sentiments by Ouédraogo and Sundby (2014), who concluded that vulnerability to unsafe abortions increases among girls with poor access to resources (finances, level of school, social network), and usually, they bear heavier consequences in terms of delayed access to care and cost compared to their counterparts who have access to these resources.

Provider-patient interaction during PAC

For those who ended up with complications and had to seek PAC in public health facilities, our findings highlighted the delays in seeking care due to most girls fearing stigma, as demonstrated by other studies (Ouedraogo and Juma, 2020; Izugbara et al., 2017). Within the health facilities, our findings show that providers diagnosed abortion complications using physical examinations together with ultrasound scans. However, for rural health facilities that lacked ultrasound services or where patients could not afford these services, providers were forced to rely on their experience and solely physical examination to deal with vital emergencies. The study also found out that it was difficult for providers to differentiate between spontaneous and induced abortion. As a result, providers relied on subjective indicators, such as age and marital status, which increased the stigma towards unmarried girls. This is contrary to a study done by Evens and colleagues in 2014 in Kenya who reported equal treatment given to women, regardless of their age or their marital status. The authors point out, however, that recall and social desirability biases may have impacted their findings.

In our study, many providers reported not offering their patients the option to choose between methods that can be used for PAC, instead often offering MVA. This was similar to findings in Argentina and Kenya, where the providers did not offer this choice (Evens et al., 2014; Ministry of Health and APHRC, 2020).

Providers' failure to involve patients in decisions on PAC services may stem from doctors' assumptions that patients are not able to make the decision (Steele and Chiarotti, 2004). And yet, previous studies show that giving patients the option for choosing the procedure for uterine evacuation can reduce stigma and obstetric violence against women (Ouedraogo and Juma, 2020). The study also concurs with a systematic review done in eastern and southern Africa, where there was low use of MA as a PAC method due to a lack of familiarity, training and guidelines on MA (Aantjes et al., 2018).

We found that not all the PAC patients were put under anesthesia or offered painkillers during the MVA procedure, resulting in very painful experiences, which may contribute to perceptions of MVA as being unsafe. This concurs with previous studies in which providers questioned the use of painkillers, citing the misperception that painkillers hinder uterine contractions (Ellen et al., 2010), or they refused to provide painkillers because they believe that the pain is a cost that must be paid for pleasure (Steele and Chiarotti, 2004). Because of this, girls and young women who experience repeat abortions may be less inclined to seek PAC services if their previous experience with MVA was very painful, and may advise their friends and peers against seeking the services as well.

Regarding the quality of their interaction with providers, some of the young women reported being talked to in a rude manner by the providers. This was found to highly affect the girls and young women's health-seeking behavior. Previous studies have also highlighted cases of mistreatment of post-abortion care patients (Ouedraogo and Juma, 2020; Steele and Chiarotti, 2004). Underlying such treatment are the perceptions of providers that young unmarried girls have transgressed norms around "respectable femininity" and "proper adolescence" (Izugbara et al., 2017). Many participants highlighted the lack of privacy and confidentiality during the care process due to the absence of a specific MVA room. This meant that the patients had to share the room with other patients, such as in the delivery room or the casualty. This posed a challenge to maintaining the privacy of the patients. This was in line with other studies, including in Kenya, where the patients' privacy was not observed during examinations due to lack of specific MVA rooms or overcrowded wards (Ministry of Health and APHRC, 2020; Steele and Chiarotti, 2004; Langer et al., 1997; Steele and Chiarotti, 2004). Patients also complained about long waiting times and referrals, which were blamed on the limited availability of trained staff and PAC equipment. This was similar to other studies where patients had to wait for long periods for a trained provider who could perform the procedure, or when the trained providers were overworked, thus causing delays (Langer et al., 1997; Mutua et al., 2018; Ministry of Health Kenya and APHRC, 2020). Taken together, these poor experiences with the quality of PAC in the form of delayed care, lack of privacy, and stigmatization, may lead to girls delaying or even giving up seeking PAC, hence increasing the burden of unsafe abortions.

Regarding costs, even though PAC is expected to be offered free in public facilities because it is an emergency service, only one of the four public facilities offered PAC services for free. In the other facilities, patients had to pay for scans and the MVA procedure. The cost of treatment led to delays in care as patients sought money. This aligns with a study done in Kenya where care was delayed for patients with limited finances to cover out-of-pocket expenses (Mutua et al., 2018).

Post-abortion contraceptive uptake

Although some PAC patients received post-abortion family planning counseling, not all of them agreed to take up contraceptive methods. Reasons why girls and young women left the facility without any method varied from a lack of autonomy (they needed their partner's permission), wanting to have children immediately, citing abstinence, having dealt with complications while using contraceptives in the past, to the contraceptives being provided in an area different from where the PAC was offered. Some patients did not receive the counseling or family planning methods because providers did not know it was supposed to be offered hand-in-hand with the PAC, or they were told to go back after two weeks for a PAC review during which family planning would be offered but they did not return. Other studies also found similar results, where there were challenges in incorporating family planning with PAC services (Bizuneh and Azeze, 2021; Evens et al., 2014; Izugbara et al., 2019; Vlassoff et al., 2012). Hence, this increases the

likelihood of repeat unplanned pregnancies and unsafe abortions. By the time we were leaving the field, two of the participants were already pregnant and they did not plan it.

SGBV as a cross-cutting theme

The study findings show that sexual and gender-based violence (SGBV) was common in Kilifi County and that SGBV is linked to unintended pregnancies and abortion in ways that often remain hidden. During facility observations, the researchers interacted with various cases of unintended pregnancies that resulted from SGBV. The most common type of sexual abuse was defilement, but there were also cases of rape and incest. Results show that some girls and young women were also victims of physical violence. These SGBV cases were often only discovered and reported (through various channels) because pregnancy ensued. For most of the defilement cases reported, the alleged perpetrators were people known to the victims and in some cases close family members.

Our research not only demonstrates a link between SGBV and unintended pregnancies, but also displays how SGBV was consistently present in women and girls decision-making and care-seeking pathways for abortion in the county. Among the 54 girls and young women followed in our study, there were four cases where the participants were forced to undergo abortion. In all these cases, the girls and young women were misled or forced to take drugs against their will. In one particular case, the participant was kidnapped and taken to the hospital against her wishes. On other occasions, girls feared they would be beaten, forced to leave their home, and forced to get married. In such instances, some girls tried to abort to avoid violence.

As they were seeking abortion services, the findings also revealed a situation where providers confessed they would sexually abuse girls, especially when they did not have money to pay for the medication. The researchers also noted cases in which healthcare providers were involved in obstetric violence against women they were treating for abortion complications. Obstetric violence can be described as mistreatment or disrespect of the rights of a person in labor or a person facing birth experiences. Obstetric violence includes being forced into procedures against one's will, or verbal harassment and beating. It has been argued that "Obstetric violence is not just about individual medical workers who mistreat women [...] this concept links unnecessary and abusive treatment and neglect during reproductive healthcare to underlying systems of inequality related to gender, race, ethnicity, class, age and geography" (Suh, 2021: 11). Indeed, it is likely that this kind of treatment takes place in some public facilities where health workers are under stress, but also where young women are implicitly or explicitly perceived by health workers as having transgressed sexual and gender norms (Izugbara et al., 2017) and, for example, deny them pain treatment (anesthesia or painkillers) as a form of punishment or slap or insult young women for not being cooperative during the procedures. It is unlikely that women who are able to pay for PAC in private facilities experience similar treatment and hence their socioeconomic conditions, on top of their gender and age, influence their vulnerability to violence during PAC.

It is a key finding of this research that abortion and SGBV are interconnected in fundamental ways. The secrecy around abortion and around SGBV make the two a perfect twin. When girls and young women have to seek abortion care in a context in which it is stigmatized, illegal in most cases and surrounded with fear, people in positions of power can abuse the women and girls in need of care. Ethnographic research has proven an entry point to start to unravel all the different ways in which the two experiences (of SGBV and abortion) are intertwined. The findings point out that more study is needed to fully understand how these topics intersect, with particular attention to unequal power dynamics and abuse and how they influence the decision-making and care-pathways around unintended pregnancies and abortion.

Conclusion and recommendations

Our findings highlight key barriers that young women and girls face in their pathways to abortion, and how these barriers impede their access to information and access to services. Because of this, girls and young women are at risk of death or disability emanating from abortion complications. There is a need to address these gaps and barriers, focusing especially on:

1. Preventing unintended pregnancies:
 - a) Widen interventions on sexuality education in the community to ensure that they are responsive to the needs of girls and adolescents who face intersectional challenges.
 - b) Redesign sexuality education interventions to involve parents, healthcare providers, CBOs and local authorities, together with young people for example by applying a “Whole School Approach”. This will ensure there is more consistency in the messages being delivered to adolescents and youth and enhance a shared understanding of the importance of this educational intervention.
 - c) Repackage SRHR/sexual education messages and information by meaningfully including young people, their parents and providers in the design, to ensure these messages speak to local conceptions and values.
 - d) Engage well-trained young people (peers) to engage with young girls, and provide them an opportunity to address their concerns with regard to the use of contraceptives, sexual activity, and SGBV. Ensure referral to youth-friendly services is guaranteed.
 - e) Map women and youth-friendly SRHR services in Kilifi and make sure this information becomes widely available.
 - f) Address fears, beliefs and myths around contraceptive methods by implementing information-education interventions with communication materials (i.e. flyers, WhatsApp messages, etc.) that speak to the concerns of girls and young women around contraceptives, information on how each method works, and their potential effect, and targeted users.
 - g) Involve men in interventions focused on contraceptive uptake and demystifying myths and misconceptions regarding its use.
 - h) Share the study findings with specific groups in the community, such as parents and community leaders to create awareness and reduce stigma around premarital pregnancies and the use of contraceptives to prevent them among young people in the community.
 - i) Provide training and opportunities to young people to equip them with skills that will help them access jobs to reduce their vulnerability and dependence.
 - j) Raise the awareness of parents on the need to provide for their girls to reduce their engagement in transactional sex.
2. Strengthen communication on abortion methods and their safety. This includes rethinking how to address the concepts of medical safety versus social safety, taking note of the perceptions of these risks held by girls and young women. This includes addressing myths around methods that are safe for abortion and paying attention to traditional methods that are being used.

3. Acknowledge unsafe abortion as a public health problem in the Kilifi County and recognize PAC as a significant form of care. Clear policies and practices are needed to ensure the provision of quality (i.e., affordable, friendly, stigma-free, and timely) PAC services in public health facilities. Improving the availability and accessibility to quality PAC services will enhance the timely use of these services by girls and women facing abortion complications. This improvement can be done through:
 - a) Allocating more financial and human resources to PAC services in public health facilities (i.e., establish a specific budget for providing PAC services, and for having dedicated providers and dedicated rooms).
 - b) Training of providers to empower them to provide quality PAC. This should include:
 - i. an inventory of trained providers in the county.
 - ii. modules on treatment procedures, task shifting, values clarification and attitude transformation (VCAT) to reduce stigma, and post-abortion contraceptive counseling.
 - iii. refresher VCAT training workshops to improve the quality of services provided by trained healthcare providers.
 - c) Improving PAC infrastructure to ensure there is functioning equipment and enough supplies. This implies engaging facility managers to ensure effective and efficient supply of medical products and equipment. There is also a need to ensure that contraceptive methods are readily available, and incorporated within the PAC wards.
 - d) Translating the existing policies (quality of care, PAC guidelines, task shifting) that are available but unknown into action at the county level in public health facilities.
 - e) Incorporating the Kenya Model Quality of Health checklist into PAC services provision, right from training, so as to improve the quality of care.
 - f) Allocating more resources at the national level towards rolling out PAC training, especially at county and sub-county facilities, in order to make the services more accessible.
4. Tackle SGBV by:
 - a) Raising community awareness of the incidence and consequences of SGBV, and of the existing legal and medical services and policies.
 - b) Involving men in SGBV sensitization and prevention programs.
 - c) Undertaking research into the intersections between SGBV, unintended pregnancies and abortion.
 - d) Creating a legal and policy environment that reduces the barriers girls and women face when seeking abortion services, especially for cases of sexual violence as per the Maputo protocol.

References

- Aantjes, C. J., Gilmoor, A., Syurina, E. V., and Crankshaw, T. L. (2018). The status of provision of post abortion care services for women and girls in Eastern and Southern Africa: a systematic review. In: *Contraception* (Vol. 98, Issue 2, pp. 77-88). Elsevier USA. DOI: <https://doi.org/10.1016/j.contraception.2018.03.014>
- APHRC, Ministry of Health Kenya, Ipas Nairobi, and Guttmacher Institute. (2013). Incidence and complications of unsafe abortion in Kenya: Key findings of a national study. DOI:10.13140/RG.2.1.3117.2328
- Bizuneh, A.D. and Azeze, G.G. (2021). Post-abortion family planning use, method preference, and its determinant factors in Eastern Africa: a systematic review and meta-analysis. *Systematic Reviews*, 10(1). DOI: <https://doi.org/10.1186/s13643-021-01731-4>
- Coast, E. and Murray, S.F. (2016). "These things are dangerous": Understanding induced abortion trajectories in urban Zambia. *Social Science and Medicine*, 153. <https://doi.org/10.1016/j.socscimed.2016.02.025>.
- Department of Economic and Social Affairs, P. D. (2015). World population prospects: the 2015 revision. Retrieved from <https://www.un.org/en/development/desa/publications/world-population-prospects-2015-revision.html>
- Ellen, M.H.M., Amata, K., Momade, U., and Hailemichael, G. (2010). Choosing early pregnancy termination methods in Urban Mozambique. , 71(1), 62–70. DOI:10.1016/j.socscimed.2010.03.025
- Evens, E., Otieno-Masaba, R., Eichleay, M., McCarraher, D., Hainsworth, G., Lane, C., Makumi, M., and Onduso, P. (2014). Post-abortion care services for youth and adult clients in Kenya: A comparison of services, client satisfaction and provider attitudes. *Journal of Biosocial Science*, 46(1), 1-15. DOI: <https://doi.org/10.1017/S0021932013000230>
- Guillaume, A., Rossier, C., and Reeve, P. (2018). Abortion around the world. An overview of legislation, measures, trends, and consequences. *Population*. 73. DOI: 10.3917/pope.1802.0217
- Håkansson M., Oguttu M., Gemzell-Danielsson K, and. Makenzius M. (2018). Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya. *BMJ Global Health*. 3(2) 3:e000608. DOI: 10.1136/bmjgh-2017-000608
- Izugbara, C., Egesa, C., Kabiru, C., and Sidze, E. (2017). Providers, Unmarried Young Women, and Post-Abortion Care in Kenya. *Studies in Family Planning*. 48:4, 343-358. DOI: 10.1111/sifp.12035
- Izugbara, C., Wekesah, F. M., Sebany, M., Echoka, E., Amo-Adjei, J., and Muga, W. (2019). Availability, accessibility and utilization of post-abortion care in Sub-Saharan Africa: A systematic review. *Health Care for Women International* (Vol. 41, Issue 7, pp. 732–760). Bellwether Publishing, Ltd. DOI: <https://doi.org/10.1080/07399332.2019.1703991>
- Jones, R.K. and Kooistra, K. (2011). Abortion Incidence and Access to Services In the United States, 2008. *Perspectives on Sexual and Reproductive Health*, 43(1). DOI: <https://doi.org/10.1363/430411>
- Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, National Council for Population and Development/Kenya, and ICF International. (2015). Kenya Demographic and Health Survey (2014). Rockville, MD, USA. Retrieved from <https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf>

- Kriel, Y., Milford, C., Cordero, J., Suleman, F., Beksinska, M., Steyn, P., and Smit, J.A. (2019). Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. *Reproductive Health*.16(1):89. DOI: 10.1186/s12978-019-0749-y. PMID: 31238960; PMCID: PMC6593556.
- Langer, A., García-Barrios, C., Heimbürger, A., Stein, K., Winikoff, B., Barahona, V., Casas, B., and Ramírez, F. (1997). Improving post-abortion care in a public hospital in Oaxaca, Mexico. *Reproductive Health Matters*. 5(9), 20-28. DOI: [https://doi.org/10.1016/S0968-8080\(97\)90002-1](https://doi.org/10.1016/S0968-8080(97)90002-1).
- Ministry of Health and African Population and Health Research Center. (2020). Quality of post-abortion care in Kenya. Findings from a national survey. Nairobi, APHRC, Kenya.
- Mutua, M. M., Manderson, L., Musenge, E., and Ochieng Achia, T. N. (2018). Policy, law and post-abortion care services in Kenya. *PLoS ONE*, 13(9). DOI: <https://doi.org/10.1371/journal.pone.0204240>.
- National Council for Law Reporting. (2010). Constitution of Kenya, 2010 revised ed., Nairobi, Kenya: NCLR with Authority of the Attorney General. Retrieved from <http://kenyalaw.org/kl/index.php?id=398>
- Ochako, R., Mbondo, M., Aloo, S., Kaimenyi, S., Thompson, R., Temmerman, M., and Kays, M. (2015). Barriers to modern contraceptive methods uptake among young women in Kenya: A qualitative study. *BMC Public Health*, 15(1). DOI: <https://doi.org/10.1186/s12889-015-1483-1>
- O'Donnell, J., Goldberg, A., Lieberman, E., and Betancourt, T. (2018). "I wouldn't even know where to start": unwanted pregnancy and abortion decision-making in Central Appalachia. *Reproductive Health Matters*. 26:54, 98-113. DOI: 10.1080/09688080.2018.1513270
- Ouedraogo, R. and Juma, K. (2020). From the shadows to light. Perceptions of women and healthcare providers of post-abortion care in Burkina Faso. *Social Science and Medicine*. 260. DOI: <https://doi.org/10.1016/j.socscimed.2020.113154>
- Ouédraogo, R. and Sundby, J. (2014). Social Determinants and Access to Induced Abortion in Burkina Faso: From Two Case Studies. *Obstetrics and Gynecology International*. 2014. 1-6. DOI: <https://doi.org/10.1155/2014/402456>
- Ouedraogo, R., Senderowicz, L., and Ngbichi, C. (2020). "I wasn't ready": abortion decision-making pathways in Ouagadougou, Burkina Faso. *International Journal of Public Health*. 65(4) 477-486. DOI: <https://doi.org/10.1007/s00038-020-01359-6>
- Republic of Kenya. (2007). Gender Policy in Education. Nairobi: Ministry of Education.
- Sedlander, E., Bingenheimer, J.B., Thiongo, M., Gichangi, P., Rimal, R.N., Edberg, M., & Munar, W. (2018). "They Destroy the Reproductive System": Exploring the Belief that Modern Contraceptive Use Causes Infertility. *Studies in Family Planning*. 49:4, 345-365. DOI: 10.1111/sifp.12076
- Ssewanyana, D., Mwangala, P.N., Marsh, V., Jao, I., van Baar, A., Newton, C.R., & Abubakar, A. (2017). Young people's and stakeholders' perspectives of adolescent sexual risk behavior in Kilifi County, Kenya: A qualitative study. *Journal of Health Psychology*. DOI: 10.1177/1359105317736783
- Steele, C. & Chiarotti, S. (2004). With everything exposed: Cruelty in post-abortion care in Rosario, Argentina. *Reproductive Health Matters*. 12(24 SUPPL.), 39-46. DOI: [https://doi.org/10.1016/S0968-8080\(04\)24021-6](https://doi.org/10.1016/S0968-8080(04)24021-6)
- Suh, S. (2021). *Dying to Count: Post-Abortion Care and Global Reproductive Health Politics in Senegal*. Rutgers University Press.

Singh, S. (2006). Hospital admissions resulting from unsafe abortion: estimates from 13 developing countries. *Lancet*. 2006. Nov 25;368(9550):1887-92. DOI: 10.1016/S0140-6736(06)69778-X. PMID: 17126721

Singh, S., Remez, L., Sedgh, G., Kwok, L., and Onda, T. (2017). *Abortion Worldwide 2017: Uneven Progress and Unequal Access*. New York: Guttmacher Institute, 2018. Retrieved from <https://www.guttmacher.org/report/abortion-worldwide-2017>

Van der Sijpt, E. (2014). The Unfortunate Sufferer: Discursive Dynamics around Pregnancy Loss in Cameroon. *Medical Anthropology*. 33:5, 395-410. DOI: 10.1080/01459740.2013.828286

Vlassoff, M., Hossain, A., Maddow-Zimet, I., Singh, S., and Ullah Bhuiyan, H. (2012). Menstrual Regulation and Post-abortion Care in Bangladesh: Factors Associated with Access to and Quality of Services. Retrieved from <https://www.guttmacher.org/report/menstrual-regulation-and-postabortion-care-bangladesh-factors-associated-access-and-quality>



**African Population and
Health Research Center**

APHRC Campus, 2nd floor, Manga Close off Kirawa road, Kitisuru. P.O Box 10787-00100 Nairobi, Kenya.

Office line : +254 020 400 1000, Office Cell: 0722 205 933 or 0733410102 Fax: +254 20 400 1101

Email: info@aphrc.org, Twitter: [@aphrc](https://twitter.com/aphrc), Website: www.aphrc.org