The Status of Safe Abortion In Kenya

A BASELINE REPORT
1 Background to the Report 9
1.1 Introduction 9
1.2 Purpose and Specific Objectives of the Baseline Survey 9
1.3 Methodology – An Innovative Approach 10
1.4 The Study Design 11
1.5 Data Collection Methods 11
1.6 Ethical Consideration 12
1.7 Data Management Plan 12
1.8 Data Analysis 12
1.9 Quality Assurance 12

2 Situation Analysis of Unsafe Abortion in Kenya 13
2.1 Background 13
2.2 Safe Abortion Methods 14
2.3 Unsafe Abortion: A Global Perspective 16
2.4 An Overview of the Un-Safe Abortion Situation in Kenya 17
2.5 Association between Abortion, Fertility Rate and Sexual Activity 20

3 Review of Legal and Policy Frameworks on Abortion 21
3.1 Abortion Laws and Policy Situation Globally 21
3.2 Policy and Abortion Laws: Situation in African Countries 23
3.3 Abortions Laws and Policy in Kenya 23
3.4 East Africa Policies Influence in Kenya 25

4 Results of the Baseline Survey 26
4.1 The Mapping of SRHR Stakeholders 26
4.2 Explorations of Perceptions And Awareness of Young Men And Women With Regards to the Subject of Safe Abortion 27
4.2.1 Awareness about the Subject of Abortion 27
4.2.2 Awareness about where girls seek abortion services and methods used 28
4.2.3 Cost of abortion 28
4.2.4 Reasons why young girls and women may procure an abortion 28
4.2.5 Attitudes of health care providers (HCP) when confronted with an abortion request 29
4.2.6 Awareness about constitutional, legal and policy frameworks on abortion in Kenya 29
4.2.7 Views about what other members of family and society feel about the subject of abortion 29
4.2.8 On Stigma And Discrimination 30
### 5 Discussion

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>The Situation Analysis of Safe and Unsafe Abortions in Kenya</td>
<td>38</td>
</tr>
<tr>
<td>5.2</td>
<td>Challenges and Barriers to Accessing Safe and Legal Abortions in Kenya</td>
<td>39</td>
</tr>
<tr>
<td>5.3</td>
<td>Key Stakeholders in the SRHR Space</td>
<td>37</td>
</tr>
<tr>
<td>5.4</td>
<td>Legal and Policy Gaps on the Status of Abortion in Kenya</td>
<td>41</td>
</tr>
<tr>
<td>5.5</td>
<td>Debates Among Health Care Providers (HCPS) in Provision of Abortion Services</td>
<td>43</td>
</tr>
<tr>
<td>5.6.1</td>
<td>Selected Country Case Studies Synthesis</td>
<td>44</td>
</tr>
<tr>
<td>5.6.2</td>
<td>Selected Kenyan Counties Synthesis: Reviewed Legal and Policy Frameworks</td>
<td>48</td>
</tr>
</tbody>
</table>

### 6 Conclusions and Recommendations

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Strategic Advocacy Approaches</td>
<td>50</td>
</tr>
<tr>
<td>6.2</td>
<td>Creation of Awareness About Legal, Policy Frameworks and Abortion Services at All Levels in the Community</td>
<td>50</td>
</tr>
<tr>
<td>6.3</td>
<td>Addressing Policy and Legal Barriers through Strengthening Policy Frameworks</td>
<td>51</td>
</tr>
<tr>
<td>6.4</td>
<td>Addressing unsafe abortion through Health Standards and Guidelines</td>
<td>51</td>
</tr>
</tbody>
</table>

### 7 Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>The Work Plan</td>
<td>53</td>
</tr>
<tr>
<td>II</td>
<td>The Financial Proposal</td>
<td>54</td>
</tr>
<tr>
<td>III</td>
<td>Informed Consent Letter</td>
<td>56</td>
</tr>
<tr>
<td>IV</td>
<td>Guiding Questions for Key Informants, Focus Group Discussions</td>
<td>57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Model For Analyzing an Advocacy Process for Influencing Public Values and Policy</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Number of Unsafe Abortions by Region</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>Abortion Rates in Africa</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>Induced Abortion Rates per 1,000 Women aged 15-19</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>Declining Rates of Abortion in Developed Countries</td>
<td>22</td>
</tr>
<tr>
<td>6</td>
<td>Declining Rates of Abortion in Developed Countries</td>
<td>45</td>
</tr>
<tr>
<td>7</td>
<td>Distribution of Abortion Safety Categories Grouped by Legal Status</td>
<td>46</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
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<tr>
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<td></td>
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<td>African Women's Development and Communication Network</td>
<td></td>
</tr>
<tr>
<td>FBOs</td>
<td>Faith Based Organisations</td>
<td></td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
<td></td>
</tr>
<tr>
<td>FGM</td>
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<td></td>
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<tr>
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<td>Family Health Options Kenya</td>
<td></td>
</tr>
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<td>HCPs</td>
<td>Health Care Providers</td>
<td></td>
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<td>IUD</td>
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<td></td>
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<tr>
<td>JHPIEGO</td>
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<td></td>
</tr>
<tr>
<td>KDHS</td>
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</tr>
<tr>
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<td>Kenya Legal and Ethical Issues Network on HIV/AIDS</td>
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</tr>
<tr>
<td>KIs</td>
<td>Key Informant Interviews</td>
<td></td>
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<tr>
<td>KMDP</td>
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<td>Program for Appropriate Technology in Health</td>
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<td>PYN</td>
<td>Pwani Youth Network</td>
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<tr>
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<td>Safe Abortion Care</td>
<td></td>
</tr>
<tr>
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<td>Sustainable Development Goals</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
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<td></td>
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<td>Supreme Council of Kenya Muslims</td>
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<td>Trust for Indigenous Culture and Health</td>
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<td>World Health Organization</td>
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The Federation of Women Lawyers (FIDA Kenya) appreciates the financial support from The Swedish Association for Sexuality Education- RFSU to conduct a baseline survey on Safeguarding Constitutional Rights to Safe and Legal Abortion for Girls and Women in Kenya. We thank RFSU for their generous support to FIDA Kenya. The support enabled the commissioning of this Survey which we believe will go a long way in facilitating service delivery to Kenyan women. The survey was conducted in four Counties- Nairobi, Mombasa, Nakuru and Kisumu.

Sincere gratitude goes to the respondents in Nairobi, Mombasa, Nakuru and Kisumu who offered the information and demonstrated tremendous willingness and support in the data collection exercise. Without their honest and incisive views, opinions and experiences, this survey would not have been possible.

We are indebted to each and every one who generously dedicated their valuable time to contribute to the survey process. Special thanks go to FIDA Kenya staff Miriam Wangari Wachira, Samson Orao, Alice Maranga and Olivia Luusah that worked through the development of the report. We appreciate the support and guidance from the FIDA Kenya Board led by Chair Josephine Mongare.

Special thanks to go to Dr. Tammary Esho – the consultant – who led and facilitated survey. We appreciate the input from key government ministry officials, stakeholders working in the provision of services or information around safe and legal abortions; Marie Stopes, Ministry or Health at the national and county levels, Directorate of Reproductive Health, Sexual Reproductive Health Alliance (SRHR) Sexual Reproductive Rights Organization (IPAS), Family Health Options Kenya (FHOK), National Alliance of Youth and Adolescents, Centre for the Study of Adolescent, African Women’s Development and Communication Network (FEMNET), National Organization of Peer Educators (NOPE), Faith Based Organizations such as SUPKEM, NCCK, Kenya National Commission on Human Rights (KNCHR), and the National Gender and Equality Commission (NGEC),

Teresa Omondi Adeitan
Executive Director – FIDA Kenya
Background

FIDA Kenya received funding to implement a five-year project entitled ‘Safeguarding the constitutional rights to safe and legal abortion for girls and women in Kenya’, a national advocacy project that aims to improve legal and policy environment for improving access to safe and legal abortion in Kenya. This project is anticipated to have the following deliverables:

i. A situation analysis of safe vis-a-vis unsafe abortion in Kenya;

ii. Recommendation of the need to reinstate national guidelines related to safe abortion care in order to reduce the morbidity and mortality related to unsafe abortions and

iii. Research evidence identifying legal and policy gaps regarding unsafe abortion that will subsequently support the enactment of the reproductive health bill.

The overall purpose of this baseline survey is to examine the status of safe abortion in Kenya with specific objectives being to:

- assess the current situation in regards to safe abortion;
- assess barriers to accessing safe and legal abortion in Kenya;
- map the stakeholders in the reproductive health space that can be key in advocacy efforts for the reinstatement of the national Standards and Guidelines on Reducing Mortality and Morbidity from Unsafe Abortion and the enactment of the Reproductive Health Care Bill;

- examine the legal and policy situation in regards to safe and legal abortion in Kenya; and

- identify best practices in conducting legal and policy advocacy on safe abortion.

- The study also sought to develop well-articulated recommendations on how to actualize the enjoyment of safe and legal abortion by girls and women in Kenya.

Methods

This assignment employed a multi-method participatory design to look at primary and secondary data sources of information that informed the situation analysis. The study used a combination of desk analysis, key informant interviews, in-depth interviews, and focus group discussions with various stakeholders to gather relevant information. These stakeholders included those that provide; SRHR services, educational programmes, advocacy and awareness interventions, psycho-social support to girls and women, and legal and policy advocacy. The study also reached out to religious organizations and groups, government ministry officials and health care providers among others.

Findings

The majority of stakeholders in the field of SRHR raised their concerns in the lack of health care guidelines to prevent and manage complications from unsafe abortions in Kenya. These guidelines are believed will increase the capacity of Health Care Providers (HCPs) in prevention and management of unsafe abortions which will subsequently
reduce abortion-related maternal mortality and morbidity rates. Human rights stakeholders strongly advocated for the amendment of sections of the penal code and the 2010 Kenyan constitution to ensure harmonization and more clarity on abortion provisions to avoid confusion and divergent interpretation.

Work closely with Sexual Reproductive Health and Rights (SRHR) stakeholders, religious and community opinion leaders in order to develop mutually agreeable ways of breaking the silence surrounding the adverse effects caused by high rates of unsafe abortion. Working directly with such important players can help them appreciate the negative effects of unsafe abortion and turn them into important advocates of a lasting solution. Establish strategic partnerships with relevant organizations that share similar agenda. This will create synergy through responsibility and knowledge.

**Recommendations**

From the baseline survey findings, the following summary of recommendations should be considered to ensure success of the upcoming programme:

- There is need for the government to have policies that will support the tackling of unsafe abortions. Reinstatement of the standard guidelines for healthcare providers to prevent and manage abortion complications was recommended, in order to reduce maternal mortality and morbidity.
- There is need for the government to have budgetary allocation on family planning, and on awareness creation among the reproductive age group.
- The government to have in place policy and guidelines on the right to contraceptives among reproductive age groups.
- There is need for enhanced education on sexual and reproductive health issues in the community and especially those associated with prevention of unsafe abortion practices.
1.0 BACKGROUND TO THE REPORT

1.1 Introduction

This baseline survey was commissioned by the Federation of Women Lawyers (FIDA Kenya), with an objective to undertake a situation analysis of the issue of abortion in Kenya, specifically the status of safe vis-a-vis unsafe abortion in Kenya, identification of policy and legal gaps with regards to safe abortion. FIDA Kenya is a non-governmental organization registered in 1985 whose mission is to promote women’s individual and collective power to claim their rights in all spheres of life. FIDA Kenya being a membership organization with over 1,100 women lawyers and law students committed to the creation of a society that is free from all forms of discrimination against women in Kenya and envisions having a society that fully respects and upholds women’s rights. FIDA Kenya prides in promoting access to justice through providing legal aid services, education and awareness creation, public interest litigation, mediation, psychosocial counselling and legal and policy advocacy programmes that positively impact on structural, institutional, and legal reforms within Kenya to ensure gender sensitivity and responsiveness. FIDA Kenya is dedicated to combat human rights abuse and practices that perpetuate gender discrimination such as Female Genital Mutilation (FGM), political discrimination, and sexual and gender-based violence.

FIDA Kenya has received funding to implement a five-year project entitled ‘Safeguarding constitutional rights to safe and legal abortion for girls and women in Kenya’, a national advocacy project that aims to improve legal and policy environment for improving access to safe and legal abortion in Kenya. This project is anticipated to have the following deliverables:

iv. A situation analysis of safe vis-a-vis unsafe abortion in Kenya,
v. Recommendation of the need to reinstate national guidelines related to safe abortion care in order to reduce the morbidity and mortality related to unsafe abortions and
vi. Research evidence identifying legal and policy gaps regarding unsafe abortion that will subsequently support the enactment of the reproductive health bill.

1.2 Purpose and specific objectives of the baseline survey

The overall purpose of the baseline survey was to examine the status of safe abortion in Kenya. To achieve this purpose, the following specific objectives were pursued:

i. Assess the current situation in regards to safe abortion.

ii. Assess the barriers to accessing safe and legal abortion in Kenya.

iii. Map the stakeholders in the reproductive health space that can be key in advocacy efforts for the reinstatement of the national Standards and Guidelines on Reducing Mortality and Morbidity from Unsafe Abortion and the enactment of the Reproductive Health Care Bill.

iv. Examine the legal and policy situation in regards to safe and legal abortion in Kenya.

v. Identify best practices in conducting legal and policy advocacy on safe abortion.
vi. Make recommendations on how to actualize the enjoyment of safe and legal abortion by girls and women in Kenya.

1.3 Methodology – An innovative approach

This baseline survey adopted a mixed-method approach where both primary and secondary method was extensively used with the set research objectives informing the design, planning and implementation of the survey. The methodology adopted led to the development of data collection tools used to get information from the various Sexual Reproductive Health and Rights (SRHR) stakeholders, faith-based groups, young men and women that participated in the study including service providers, policy makers as well as young girls and women who might seek abortion services. These included:

- FIDA Kenya
- Ministry of Health Officials including the Division of Reproductive Health
- Ministry of Public Service Youth and Gender Affairs
- Non-Governmental Organizations (NGOs), Community Based Organizations (CBOs), Faith Based Organizations (FBOs), Civil Society Organizations (CSOs) dealing with SRHR and policy issues, key populations, adolescent reproductive health, and women’s reproductive health among others
- SRHR Alliance, IPAS, Family Health Options


This innovative method relied on the Theory of Change for policy advocacy approach. This approach acknowledges the complexity of policy processes which involve problem identification, development of matching solutions and the political processes which are viewed as “multiple streams” that flow independently and simultaneously where in each different actors may take part in. By adopting the above Theory of Change, this baseline gauged the upcoming ‘Safeguarding constitutional rights to safe and legal abortion for girls and women in Kenya’ project against well tested approaches and best practices in advocacy programming. The Theory of Change ensures that such projects are focused on long-term, coordinated and holistic strategies that engages all relevant stakeholders at every stage of policy strengthening and implementation by all actors.

In line with this Theory of Change, this survey begins by identifying the situation analysis of safe vis-a-vis unsafe abortions practices in Kenya, gaps in the legal and policy environments as well as provide recommendations for improving access for safe and legal abortions in Kenya. It acknowledges that if the following outcomes are realized;

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2. IBID
• A strong evidence base that supports innovative delivery of quality, accessible and affordable safe abortion services to women and girls who need them,
• Enactment of policies and practices are adopted to ensure correct use of guidelines,
• Commitment to implement solutions that ensure availability and proper usage will subsequently expand access to life saving safe abortion services through a comprehensive abortion care package that will reduce maternal mortality and morbidity in Kenya.

1.4 The Study Design
This baseline survey employed a multi-method participatory approach in sourcing and analyzing primary and secondary data leading to vast information that informed the situation analysis. Field work was conducted in the four focus counties of FIDA Kenya: Nakuru, Mombasa, Kisumu and Nairobi. Several stakeholders were reached through qualitative approaches; Key Informant Interview (KII), Focus Group Discussion (FGD), and In-depth Interviews (II). These stakeholders were: SRHR stakeholders, CBOs, CSOs, FBOs, young women and men.

1.5 Data Collection Methods
This study employed several data collection methods used to enable triangulation of data in order to have richness of findings. The following methods were employed:

a) Desk Reviews: The survey team reviewed documents and reports related to the project that provided essential background information to inform a situation analysis of safe abortion vis a vis unsafe abortion in Kenya. An online search was conducted using search terms such as ‘abortion’ ‘unsafe abortion’ ‘safe abortion’ ‘abortion complications’ ‘sexual and reproductive health’ ‘maternal health’ ‘unwanted pregnancy’ ‘unplanned pregnancy’ among others. Grey literature and reports reviewed were obtained from FIDA Kenya, human rights organizations such as EACHRights, Centre for the Study of Adolescents, APHRC, IPAS, SRHR Alliance, among others. The provisions of the Kenyan Constitution were reviewed, others included Kenya Demographic and Health Survey (KDHS) reports, and peer reviewed journals, policies such as the Kenya Adolescent Reproductive Health and Development Policy developed in 2003 and the Kenya National Reproductive Health Policy among others.

b) Key Informant Interviews (KII): KIIIs were conducted to gather more information from the various sexual and reproductive health stakeholders, health care providers, religious and human rights organizations. These were: the FIDA Kenya representatives, key government ministry officials, stakeholders working in the provision of services or information around safe and legal abortions in national and county levels, Directorate of Reproductive Health SRHR Alliance, IPAS, Family Health Options Kenya, National Alliance of Youth and Adolescents, Centre for the Study of Adolescent, African Women’s Development and Communication Network (FEMNET), National Organization of Peer Educators (NOPE), Faith Based Organizations such as SUPKEM, NCCK, Kenya National Commission on Human Rights (KNCHR), and the National Gender and Equality Commission (NGEC), to pick their views about the issue of safe vis a vis unsafe abortion, policies that safeguard the health of women, provision of safe abortion services, complications and management of abortions, advocacy efforts, awareness and sensitization programs to girls and women among other SRHR interventions.

c) Focus Group Discussions (FGDs): FGDs were conducted in each of the FIDA focus counties i.e. Nakuru, Kisumu, Nairobi and Mombasa. The FGDs were conducted in order to get perspectives regarding the issue of abortion access, awareness, legal, medical, and policy and advocacy issues. A sample of 4 groups of 8 young men and women of reproductive age group were purposively selected from those
that benefit from various SRHR organizations’ activities in the four different counties.

d) **In depth interviews** with women/girls receiving post abortion care. In-depth interviews with young girls, women, people living with special needs such as those living with HIV/AIDS, Key Populations among others who may require abortion services at some point in their lives were also conducted. The study also sought women who had conducted abortions from any hospital facilities in Kenya. Snowballing was used from the FGDs by the researcher to identify a woman/girl who had undergone abortion then recruited her for an IUD. Following the IUD, the girl or girls identified their friends or network that had undergone abortion through snowballing method.

e) **Mapping of Key Stakeholders** who work in the reproductive health space and especially around safe and legal abortion in Kenya.

The survey mapped out key stakeholders working in the sexual reproductive health space in different parts of Kenya. This was done through desk reviews as well as through snowballing from the stakeholders being interviewed, their partners and collaborators. These stakeholders were mapped based on the following:

i. Geographical location – their areas of jurisdiction e.g. Western Kenya, North Eastern Kenya etc.

ii. Identification of their specific mandate and function, services or products offered with regard to safe abortion practices e.g. medical, legal, advocacy, etc.

1.6 Ethical Consideration

This study is anchored on ethical consideration, and the “do no harm principle” in all the activities, processes and implementation stages. Ethical clearance was sought from an accredited ethical review committee of the Great Lakes University of Kisumu (GLUK). Administrative clearance was granted from participating institutions and informed consent was obtained from all participants.

1.7 Data Management Plan

Qualitative data from FGDs and key informant interviews was transcribed verbatim into MS Word files using thematic templates by the data clerk. The interpretation of the results is presented in depth and reported into narrative style in the analysis and discussion chapters. The qualitative data analysis utilizes a thematic analysis approach with all data collected including the field notes and personal comments assembled as expressed by the stakeholders.

1.8 Data Analysis

Data from the literature review of published sources, or literature, on a particular topic was critically analyzed. The analysis of literature was summarized, classified and interpreted. The study’s field work data was transcribed verbatim every evening. The transcripts analyzed using thematic framework analysis for qualitative data from the KII, FGDs and IIs. The framework approach was developed in the 1980’s by social policy researchers at the National Centre for Social Research as a method to analyze qualitative data applied to policy research.³

1.9 Quality Assurance

The consultants guarantee quality through an elaborate system of checks that ensure all quality control measures were adhered to daily during the survey. These include but not limited to; training of research assistants about the data collecting processes and ethical issues regarding the sensitive topic of abortion, reviewing of the study tools, pre-testing of tools; data collection supervision against a survey quality control checklist; cross-checking completed tools (for accuracy, correctness, consistency and completeness) and data cleaning.

There were multiple levels of review during data collection and submission. The study team employed use of various methods to gather information mainly for triangulation, explanation and in-depth understanding of the observations and findings. The active involvement of the FIDA Kenya staff, the consultants and other key stakeholders in the process also ensured objectivity and reduced biases.

2.0 SITUATION ANALYSIS OF UNSAFE ABORTION IN KENYA

2.1 Background

Unsafe abortion remains a serious pandemic and public health issue worldwide. The World Health Organization (WHO) defines unsafe abortion as a procedure of pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. Unsafe abortion is identified as one of the major causes of maternal morbidity and mortality as it tends to be clandestine and unsafe. The WHO estimates that unsafe abortion contributes to 13% of maternal deaths worldwide.

A systematic review that investigated the prevalence of unsafe abortion and its associated factors in Sub-Saharan Africa (SSA) revealed that there is a gap in the availability of complete data on unsafe abortion and this can negatively influence the prevailing service delivery. The study continues to say that whether legal or illegal, induced abortion is usually stigmatized and frequently censured by political, religious, or other cultural issues and therefore under-reporting is routine even in countries where

Figure 2 Number of unsafe abortion by regions


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5https://www.who.int/reproductivehealth/about_us/en/
abortion is legally available. Secondary to unsafe abortion is 950 times higher in SSA (520) than in the USA (0.6) per 100,000 live births, respectively.

Grimes et al. (2006) provided estimates that show women in South America, Eastern Africa, and Western Africa are more likely to have an unsafe abortion than women in other regions. The unsafe abortion rates per 1000 women aged 15–44 years (Figure 2) provide a more comparable measure of unsafe abortion by region. In Asia, south-central and south-eastern regions have similar unsafe abortion rates (22 and 21 per 1000 women, respectively), whereas the rate is about half (12 per 1000) in Western Asia and negligible in Eastern Asia where abortion is legal on request and easily available.

The burdens of unsafe abortion and its associated maternal mortality are disproportionately higher for women in Africa than in any other developing region. Its share of global unsafe abortions was 29%, and more seriously, 62% of all deaths related to unsafe abortion occurred in Africa in 2008, while in places where laws and policies allow abortion under broad indications, the incidence of mortality from unsafe abortion are reduced.

While the average percentage of abortions per total number of pregnancies dropped in the world, Africa and other developing countries recorded a rise. Between 1990-1994 and 2010-2014, developed countries recorded a drop from 39% to 27% in proportion of pregnancies ending in abortion while developing countries recorded a rise from 21% to 24% within the same period. Over the 2010-2014 period, an average of 56 million induced abortions occurred annually across the world with 49 million of these happening in developing countries. This signifies an annual abortion rate of about 35 per every 1,000 individuals of reproductive age (15–44 years). Research has shown that the higher likelihood of women in the developing world to have an unsafe abortion as compared to those in the developed world can be associated with higher levels of unmet need for contraceptives. Indeed, 56% of women having unplanned pregnancies end up inducing an abortion.

Work by Grimes et al. show that a high proportion, of about 20 – 50% of women who have procured unsafe abortions develop complications that lead to hospital admission. Some of the commonest unsafe abortion related complications include hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus, and abdominal organs.

The World Health Assembly identified unsafe abortion as a public health concern in 1967, but the extent of this public health problem was understood after the 1987 Safe Motherhood Conference and the publication of first estimate of abortion-related deaths in 1989. Many decades later, unsafe abortion is still a major public health concern all over the world.

Despite the gains made globally to reduce maternal mortality caused by unsafe abortions, estimates show a high prevalence of deaths due to unsafe abortions with 1 in 8 deaths globally and 1 in 5 deaths in Eastern Africa being attributed to unsafe abortion. Safe abortion has been found to contribute to reduction in maternal mortality and morbidity. The Sustainable Development Goals (SDGs) aim to reduce global maternal mortality ratio from 216 to 70 per 100,000 live births by 2030. In order to contribute to this goal, developing countries need to develop permissive laws on abortion and improve healthcare systems in management of abortion-related maternal deaths.

2.2 Safe abortion methods

The Center for Disease Control and Prevention (CDC) defines a legally induced abortion as an intervention performed by a licensed clinician (e.g. a physician, nurse-midwife, nurse practitioner, or physician assistant) that is intended to terminate an ongoing pregnancy. Although abortion or

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8 https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide
9 Ibid
10 Ibid
termination of pregnancy (TOP) is increasingly becoming a normalized component of women’s reproductive health in the developed world, it is to-date a politically and religiously contentious issue in many countries in the developing world. According to WHO (2016), safe induced abortion procedures are conducted in two main ways:

i. **Medical abortion** – This involves the use of medications or pharmacological products to terminate a pregnancy. Drugs such as misoprostol and mifepristone, alone or in combination have found wide usage across the globe in medical abortion and post abortion care (WHO, 2014; WHO, 2016).

   Characteristics of medical abortion:
   a) Avoids surgery
   b) Mimics the process of miscarriage
   c) Controlled by the woman and may take place at home (<9 weeks)

   d) Takes time (hours to days) to complete abortion, and the timing may not be predictable
   e) Women may experience bleeding and cramping, and potentially some other side-effects (nausea, vomiting)
   f) May require more clinic visits than vacuum aspiration

ii. **Surgical abortion** – It involves the use of extraction of products of conception from the uterus for terminating an unwanted pregnancy, including vacuum aspiration, and dilatation and evacuation.

   Characteristics of surgical abortion:
   a) Quick procedure
   b) Complete abortion easily verified by evaluation of aspirated products of conception. Takes place in a health-care facility. Sterilization or placement of an

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14 https://www.who.int/reproductivehealth/about_us/en/
16 Ganatra et al., 2017 Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model.

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Figure 3 Abortion rates in Africa
(Source: Guttmacher Institute)
intrauterine device (IUD) may be performed at the same time as the procedure

c) Requires instrumentation of the uterus
d) Small risk of uterine or cervical injury
e) Timing of abortion controlled by the facility and provider

2.3 Un-Safe Abortion: A Global perspective

WHO statistics estimated that 21.6 million unsafe abortions were carried out in 2008 globally, increasing from the 19.7 million reported cases in 2003. Other more recent estimations show that during 2010–14, 55.7 million abortions occurred annually worldwide, of which 30.6 million (54.9%) were safe, 25.1 million were unsafe, with 24.3 million (97%) of these unsafe abortions occurring in the developing countries. This means therefore, that there is a tendency of increase in the number of unsafe abortions, with the greatest burden disproportionately affecting the developing world. Between 1995 and 2008, there was an increase in the number of unsafe abortions around the world from 44% to 49% respectively.

A review of 70 abortion related studies from 28 countries between 1994 and 2014 indicated that at least 9% of abortion-related hospital admissions had a near-miss event (complications which would have most likely resulted in death had the woman not made it to hospital) and approximately 1.5% ended up in death.

A hospital-based, cross-sectional study involving 2,067 women who went to the hospital for Post-Abortion Care (PAC), while examining the severity of abortion complications established that 72.3% of women had mild complications, 6.7% had moderate complications and 20.7% had severe complications. Case fatality rate in this study was approximately 387 deaths per 100,000 post-abortion care procedures. Another important finding in this study was that the risk of severe complications decreased slightly with an increasing level of education.

A 2018 research shows that there were 405,000 abortions in Tanzania in 2013 that translated to a national rate of 36 abortions for every 1,000 women within the child bearing age of 15-49 years and a ratio of 21 abortions per 100 live births. This national ratio of 36 abortions per 1000 women was lower than that of Kenya (48), but close to that of Uganda (39). It was however higher than the rates for Ethiopia (23), Rwanda (25) and Malawi (24) during the same period. For every safe abortion obtained from a health facility in Tanzania in 2013, there were 6 others carried out in unsafe conditions, leading to high mortality and morbidity rates, the study reported.

Comparatively, it has been shown that the proportion of women showing up in healthcare facilities for post-abortion care (PAC) with moderate to severe post-abortion complications in Kenya was as high as 77%, which is much higher than the proportions reported in Malawi (28%) and Ethiopia (41%), up from 44% proportions reported in 2002.

Unsafe abortion continues to be a leading cause of maternal mortalities in many parts of the world with the burden being disproportionately high in the resource limited setting especially in Sub-Saharan Africa. Some of the factors that have been reported to affect the delivery of safe abortion services include:

i. Policy and legal contexts;

ii. The socio-economic conditions;

iii. The availability and access of safe abortion services, including the training of healthcare providers;

iv. The stigma surrounding abortion.

The presence of either a few or all of the following conditions typically characterizes an unsafe abortion:

i. No pre-abortion counseling and advice;

ii. Abortion is induced by an unskilled provider, frequently in unhygienic conditions, or by a

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17 Ganatra et al., 2017 Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model.
health practitioner outside official/adequate health facilities;

iii. Abortion is provoked by insertion of an object into the uterus by the woman herself or by a traditional practitioner, or by a violent abdominal massage;

iv. A medical abortion is prescribed incorrectly or medication is issued by a pharmacist with none or inadequate instructions and no follow-up;

v. Abortion is self-induced by ingestion of traditional medication or hazardous substances;

vi. The lack of immediate intervention if severe bleeding or other emergency develops during the procedure;

vii. Failure to provide post-abortion check-up and care, including no contraceptive counselling to prevent repeat abortion;

viii. The reluctance of a woman to seek timely medical care in case of complications because of legal restrictions and social and cultural beliefs linked to induced abortion.

2.4 An Overview of the un-safe abortion situation in Kenya

The Kenya Reproductive Health Care Bill, 2014 defines abortion or termination of pregnancy (TOP) as the separation and expulsion by medical or surgical means, of the contents of the uterus of a pregnant woman before the foetus has become capable of sustaining an independent life outside the uterus (Kenya Reproductive Health Bill, 2014). In addition, the Kenya National Adolescent Sexual and Reproductive Health Policy developed in 2015 also describes abortion as the deliberate termination of a pregnancy, usually before the embryo or foetus is capable of independent life. In medical contexts, this procedure is called an induced abortion and is distinguished from a spontaneous abortion (miscarriage) or still birth.

The definition of un-safe abortion is defined by the Kenya National Adolescent Sexual and Reproductive Health Policy developed in 2015 as a procedure for terminating pregnancy performed by persons lacking the necessary skills or in an environment that is not in conformity with minimal medical standards or both.

Figure 4: Induced Abortion Rates per 1,000 women aged 15–49, Kenya, 2012

18https://scholarworks.gsu.edu/cgi/viewcontent.cgi?article=1529&context=iph_theses
19http://apps.who.int/medicinedocs/documents/s17116e/s17116e.pdf
20KDHS 2014/15
Unsafe abortion employs a number of crude procedures such as:

i. Vaginal insertion of sharp objects (sticks, broken glass, or knitting needles) or lemon juice on a vaginal suppository.

ii. Ingestion of drugs/chemicals (quinine, detergents, ground-tree bark/roots extract, and aloe vera) and may be performed either by the individual or by an unqualified medical personnel.

Unsafe abortion leads to a number of complications which are short-term or long term. Some of the complications are injury to the uterus, heavy bleeding, infection, infertility, chronic pain, and death. The risk of dying from abortion is disproportionately high in the developing world. It is estimated that maternal mortality rate in Kenya is 385 deaths per 100,000 live births, majority of these deaths occurring due to unsafe abortion.

In 2012 alone, 464,000 induced abortions occurred in Kenya, translating to a national rate of 48 induced abortions per 1,000 women aged between 15–49 years. The national ratio of induced abortions was estimated at 30 abortions per 100 live births, with the combined Nyanza and Western region registering the highest ratio of 40 per 100 live births, the Rift Valley region registering 39 per 100 live births with the Eastern region registering the lowest rates at 13 per 100 live births.

When classified by age, abortion rates are highest among women aged 20-24. The abortion rates were shown to almost double with increase in age from adolescents (15-19 years) to women aged between 20-24 years (from 38 per 1000 women to 76 per 1000 respectively), before declining slightly to 69 among 25–29 year-olds. The lowest rates of abortion were reported between ages 45-49 (Figure 1). This data indicates that the greatest efforts of intervention need to be targeted to younger populations for the impact of such interventions to be felt.

A national survey that investigated abortion-related care in 246 health facilities in Kenya revealed that of 77% of women seeking post abortion care, 40.1% of women had moderate and 37.1% had severe post abortion complications respectively. The same study also reported that there were several determinants of abortion complications as follows:

- **Age** – adolescents are more vulnerable to severe complications from clandestine unsafe abortions than older women. This is attributed to a lack of access to SRHR education, low contraceptive usage among other factors. It is estimated that in 2013, 10–19-year-olds accounted for 17% of all women who sought post abortion care in public facilities, and that 74% of the moderate or severe complication cases were among this group, partly because of their use of less skilled health care providers.

- **Level of education** - women with low levels of education suffer from abortion complications as compared to those with higher levels of education.

- **Proximity to urban areas** – women living in urban areas or close to urban areas are able to access safe abortion services, or access a health facility easily when suffering from abortion complications.

- **Marital status** - divorced women had significantly higher proportions of severe complications possibly due to the stigma associated with an unwanted pregnancy when unmarried.

- **Employment status** - the unemployed women and other young girls were most likely to have abortion complications than the employed possibly due to a high cost of abortion services available.

- **Delay in seeking health care** after an induced abortion - in a cross sectional study on unsafe abortion in Kenya researchers showed that...
delay in seeking care resulted in post abortion complication severity.\textsuperscript{20}

* Lack of capacity in lower level health facilities in management of post abortion complications. The study further reveals that there could be infrastructural and personnel limitations to handle more complicated cases. Referrals to higher level facilities may lead to delays in treatment due to the distance in far flung geographical locations.

The above findings are also corroborated by another Kenya SRHR alliance baseline survey. This was done to assess baseline indicators that would be used to monitor and evaluate a youth SRHR program. The study was conducted in 5 counties sampled from the region of coverage, and targeted participants of ages 10 – 24 and key persons in the community in these counties in an attempt to determine the levels of access, service delivery and knowledge of youth sexual and reproductive health services (which include safe abortion services) in the study sites.

The baseline survey found out that out of 35 health facilities interviewed in relation to provision of safe abortion services, only 74.3% of the facilities could offer confirmation of pregnancy, 65.7% had the capability to perform estimation of gestational age, 62.9% provided pre-abortion counseling, only 20% of these facilities provided surgical abortion, 37.1% provided medical abortion and 65.7% provided post-abortion counseling.\textsuperscript{23} This survey showed that some facilities were carrying out safe induced abortions under all the conditions of the liberalized law, even in cases where there were no provisions in law to procure an abortion. The report also showed that only 18% of the health facilities assessed rated themselves as fully compliant to the current safe abortion guidelines.

A research conducted in Kenya classified post abortion complications based on the level of morbidity severity of abortion into severe, moderate and low morbidity as dictated by predetermined characteristics as shown in Table 1 below.\textsuperscript{24}

<table>
<thead>
<tr>
<th>Level of morbidity severity</th>
<th>Symptoms and signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe (requires at least one criteria)</td>
<td>Death</td>
</tr>
<tr>
<td></td>
<td>Sepsis</td>
</tr>
<tr>
<td></td>
<td>Temperature &gt;37.9 degrees Celsius</td>
</tr>
<tr>
<td></td>
<td>Evidence of mechanical injury/foreign body</td>
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<tr>
<td></td>
<td>Shock</td>
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<tr>
<td></td>
<td>Pulse &gt;119 beats/minute</td>
</tr>
<tr>
<td></td>
<td>Organ or system failure</td>
</tr>
<tr>
<td></td>
<td>Generalized peritonitis</td>
</tr>
<tr>
<td></td>
<td>Tetanus</td>
</tr>
<tr>
<td>Moderate (requires at least one criteria if subject isn’t in severe)</td>
<td>Offensive products of conception</td>
</tr>
<tr>
<td></td>
<td>Temperature 37.3-37.9 degrees Celsius</td>
</tr>
<tr>
<td></td>
<td>Localized peritonitis (tender uterus, discharge)</td>
</tr>
<tr>
<td>Low morbidity</td>
<td>Temperature &lt;37.3 degrees Celsius</td>
</tr>
<tr>
<td></td>
<td>No signs of infection</td>
</tr>
<tr>
<td></td>
<td>No system or organ failure</td>
</tr>
</tbody>
</table>

\textsuperscript{23} SRHR Alliance 2013
2.5 Association between abortion, fertility rate and sexual activity

The 2014 Kenya Demographic and Health Survey reported a total fertility rate of 3.9. The survey also indicated that fertility rates decreased with increase in education and house hold wealth. This implies that uneducated girls and women with lower household income (usually among the poorest in Kenya) have higher fertility rates and are more prone to unintended pregnancies hence high abortion rates. In 2017 it was reported that in Kenya, more than 30% of adolescents aged between 15-19 years had sexual intercourse at least once and that 50% of this age group were sexually active. The high fertility rates and sexual activity among young women in Kenya indicates that there is need for targeted interventions for young women between ages 15-24.

The association between abortion and fertility rate and increased sexual activity among adolescents between the ages of 15-19 years is that of unintended pregnancies. Scientific evidence demonstrates that unintended pregnancies are the greatest predisposing factors to abortion, and unsafe abortion hence maternal mortalities and morbidities. The rates of unintended pregnancies are high in the developing countries and specifically in SSA. Globally, studies indicate that there were a total of 44% unintended pregnancies between 2010 and 2014. When categorized by sub-region, the Caribbean region had the highest rate of unintended pregnancies at 116 per 1000 women between 2010 and 2014, followed by Eastern Africa with rates of 112 per 1000 women with the lowest rates reported in northern and Western Europe. A comparison between the percentages of unintended pregnancies globally between 1990-1994 and 2010-2014 showed an increase from 59% to 69% respectively.

Unintended pregnancy in Sub-Saharan Africa accounts for more than 25% of the 40 million pregnancies recorded annually. Available evidence shows that unintended pregnancy increases the risk of adverse pregnancy and maternal outcomes, including mortality and morbidity associated with unsafe induced abortions. It has been estimated that only 17% of women aged 15-49 years are in need of contraception to avoid unwanted pregnancies in Sub-Saharan Africa. Another study further reported that a high unmet need of contraception among adolescents in Kenya, is at 52%. The Kenya Demographic and Health Survey (KDHS 2008/9) reports that 43% of married women pregnant at the time had unintended pregnancies. These high rates of unintended pregnancies are as a result of demonstrated poor uptake of contraception especially among populations most at risk of unintended pregnancies such as adolescents and young women. This indicates that an even greater percentage of adolescents, with poor awareness and access to contraceptives are at a higher risk of unintended pregnancies. It is thus imperative that strategies to combat the high rates of unintended pregnancies will be an important component of fighting unsafe abortions.
3.1 Abortion Laws and Policy Situation Globally

World over, maternal mortality and morbidity regrettably continues to be a preventable tragedy that affects women, babies and families. Estimates by WHO show that unsafe abortion case fatality rate for Eastern Africa remain as high as 1,000 deaths per 100,000 live births.\(^{30}\) Global experience and best practices have shown less restrictions on abortion coupled with increased access to safe abortion services can significantly reduce the high maternal mortality and without increasing abortion rates. What this means is, contrary to common belief, legalizing abortion will not increase the number of abortions but rather convert the current unsafe abortions to safe abortions\(^ {31}\). This directly reduces the costs that families and states incur while treating complications related to unsafe abortions, with such funds being channeled towards supporting access to safe abortion and creating alternatives for girls and women having unintended pregnancies.

Union of Soviet Socialist Republics (USSR) was the first nation to reform and liberalize its abortion laws in 1920. Since then, various international policies and guidelines initiated with the help and influence of international human rights bodies were published. Some of these include the 1966 Covenant on Economic, Social and Cultural Rights, the 1979 Convention on the Elimination of all Forms of Discrimination against Women, the 1995 Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women, and the 2000 United Nations Millennium Development Goals\(^ {32}\). These international abortion-related laws have had an impact on the progressive consideration of the issue of abortion at both regional and individual states throughout the world. Therefore, they have great influence on the situation of criminal restrictions in this area. Pursuant to this, statute laws are registrations or parts of penal or criminal codes consolidating criminal statutes.

Though abortion was initially criminalized in the UK in sections 58 and 59, the case was re-examined and permitted in 1967 Abortion Act based on specific conditions and grounds. The Act has since been amended further to bring clarity to the provisions. Despite this, some of the earlier acts remain in force to regulate illegal abortions in the country.

Other countries have followed the UK’s example such as Sierra Leone by revoking the Offences against the Person Act of 1861 and replaced it with a Safe Abortion Act in 2015 to provide legal grounds for abortion in the country. Many other countries have since followed suit, and by the last quarter of the 20th century, 98% of the countries across the globe had legal provisions allowing abortion services to protect and save the mother’s life\(^ {30}\). Other existing grounds for legalized abortion also varies across the globe with preservation of the mental health of the woman taking a 62% proportion, impairment or anomaly of the fetus with 39%, 63% for the physical health of the mother,


33% for social economic reasons, 43% for incest or rape and 27% for on demand/request. In relation to this, the WHO guidance policy on “Safe abortion care: the public health and human rights rationale” indicated that in countries where legislation is not as restrictive and allows for abortion under broad indications, there is reported lower incidence of complications from unsafe abortion than in areas where abortion is legally more restricted.

China is a global special case when it comes to abortion laws. In 1971, the country rolled out the implementation of a family planning policy. The absence of any provision criminalizing termination of pregnancy with the consent of the mother in the criminal code of China enacted in 1979 further supported the family planning policy because abortion gradually gained speed as an alternative family planning method in the country. In fact, by then, abortion in China was on a demand basis with no restrictions. The country has a guideline providing that medical personnel can use vacuum aspiration technique to perform an early abortion in a clinic, while only physicians in a hospital can conduct an abortion in the second-trimester onwards. However, although there is an exception of medical grounds, the law in China prohibits sex selective abortion under Article 32 of the Law of the People’s Republic of China on Maternal and Infant Health Care. Moreover, the government is involved in ensuring increased access for safe abortion as well as after abortion care for women; that women have paid sick leave after an abortion has taken place.

There are other regulatory, legal and policy-based approaches that have been recently used to liberalize and improve accessibility to or restrict safe abortion in various countries. Some of these include: Precedents by the Supreme courts. For instance, Colombia in 2006, U.S in 1973 and 2016, and Brazil in 2012, Religious interpretation of Muslim law permitting abortion before the 120th day in countries such as Tunisia and UAE, Medical ethical codes.

Figure 5: Declining rates of abortion in developed countries

![Graph showing declining rates of abortion in developed regions]

http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1
Although many other countries have since loosened restrictions barring safe abortion, Kenya remains among the most restrictive ones considering the drastic reduction not only in the rate of abortion but also death related to unsafe abortion in countries without any restrictions. The figure below illustrates the gradual reduction in rates of abortion in developed countries that also double as those without abortion restrictions against the recent rising rates among the developing/those with restrictions.

3.2 Policy and abortion laws: Situation in African countries

The World Health Organization states that restrictive abortion laws characteristic of most African countries is to blame for the high cases of unsafe abortions in the region. United Nations Population division classification shows that safe abortions are legally permitted based on broad economic and social grounds. The case is unfortunately different for the developing countries including Kenya, save for countable ones.

In Kenya, the consequences of unsafe abortions are devastating. Findings show that up to 35-50% maternal deaths in the nation are caused by unsafe abortions, way higher than the 13% global estimates. South Africa is an example of a liberal-minded African country that has widened grounds for securing a safe abortion. Act no. 92 of 1996 section 2 (1) reads that a woman can terminate a pregnancy “upon request during the first 12 weeks of the gestation period of her pregnancy.” Part b and c explain the conditions for terminating pregnancy from the 13th and after 20th weeks respectively under certain grounds, while subsection 2 explicitly gives the trained health practitioners the mandate to provide these services within the confines of the law and in the designated facilities. Similarly, on 31st December 1989, Cape Verde had enacted abortion laws permitting on-demand availability of the service in the first 12 weeks of pregnancy. There are very few restrictions as well in the country. Tunisia also falls in this bracket of countries with unrestricted abortion laws.

In Kenya, available comparative data shows that 2008 recorded an abortion rate of 38 in every 1000 women within the age of 15-44 years. Moreover, it is estimated that a significant percentage rose from unsafe abortions. However, as presented by figure 2 below, Southern Africa, whose largest country (South Africa) has liberal laws had a comparatively lower sub-regional rate of abortion standing at approximately 15 for every 1000 women. This is irrespective of the fact that the country itself in 2013, saw a significant percentage of abortion remain unsafe as a result of negative attitudes, high associated costs, stigma surrounding abortion services and lack of awareness of abortion laws and services. This underscores the fact that good laws alone are not the sole solution to unsafe abortion, other strategies are key to ensure that high mortality and morbidity rates occasioned by unsafe abortion practices are reduced. Therefore, as reflected by these rates, it shows that Kenya has a long way to go in implementing both the Maputo Protocol and the 2010 Article 26 (4) in the Kenyan Constitution.

3.3 Abortion laws and policy in Kenya

Kenya outlines abortion laws in the Constitution and the Penal Code. Based on the 1970 Penal code, abortion is illegal in Kenya and a criminal activity. Although exceptions were made by the 2010 constitution, the case of abortion laws in the country remains unresolved. The 2010 constitution outlines this in Article 26 (4), while the revised 2009 edition of the Penal code does so in Articles 158-160, and 228 as well as 240.

The Right to Life is the principle guarded by Article 26 (4) of the 2010 Kenyan constitution. It states, “Abortion is not permitted unless, in the opinion of a trained health professional, there is a need for emergency treatment or the life or health of the mother is in danger, or if permitted by any other written law.”

35 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5849464/
36 http://www.kenyalaw.org/lex//actview.xql?actid=Const2010
Based on the Penal Code Cap. 63, the position of the laws of Kenya on attempts to procure abortion have been outlined by article 158. It states that “Any person who, with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years”

Article 159 focuses on the pregnant woman, and it reads: “Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years.”

The Penal Code also criminalizes supply and stocking of drugs and instruments that are used for procuring an abortion and as such, any medical practitioner performing unlawful abortions is liable to punishment including suspension or being completely erased from the Doctors’ register as stipulated by the Medical Practitioners and Dentists Board of Kenya. This is covered by Article 160 on the supply of drugs and abortion procuring instruments and it reads: “Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or is not with child, is guilty of a felony and is liable to imprisonment for three years.”

The killing of an unborn child is covered by Article 228 which states that “Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a felony and is liable to imprisonment for life.” It does not stop there because it also goes further to regulate the activities of medical professionals in Article 240 talking to the surgical operations. The article reads, “A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother’s life, if the performance of the operation is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.” The provision of this article agrees with the decriminalization exception in the 2010 Kenyan constitution.

The Reproductive Health Care Bill of 2014 comprehensively revisits the legal challenges facing Kenya in reproductive health services, and in this case with a bias on legal abortion. Section 19 (1) of Part V titled “Termination of the Pregnancy” provides that a pregnancy can be terminated when a health practitioner with requisite training recommends that the pregnancy would endanger the health and the life of the mother. Section 19 (2) directs that the procedure should only take place with the mother’s consent or after consultation with parents of a minor/carer, and the same case applies for a person who is mentally unstable.

Despite all these laws and bills in the country, the unlawfulness and unclear provision of what actually constitutes lawful abortion in Kenya remains a major legal debate. For instance in Kenya, Marie Stopes has been one of the primary advocates leading the sensitization and creation of awareness among the public on safe abortion services. However, their efforts have been met by strong opposition, including the recent banning of respective advertisements and even provision of abortion services.

Studies have revealed that even access to basic information regarding safe abortion is challenging. The obvious lack of supportive legal structures in this area has been associated with the increasing cases of unsafe procurement of abortion services from backstreet doctors.

For instance, Marie Stopes, one of the leading organizations in sensitizing people on safe abortion in Kenya faced advertisement ban and threats with legal action from the Kenya Film Classification Board on 11th September 2018. The advertisement had been running on radio weeks after the agency banned it on September 10th 2018 on claims that the campaign supports abortion of unplanned pregnancies. Subsequently, the ban which took effect on November 14, 2018, issued by the Kenya Medical Practitioners and Dentists Board. The threats were over a short clip run within the premises of Marie Stopes clinic targeting to inform visiting clients on the need to avoid unsafe abortion and instead visit trained personnel for advice and help. The declaration of abortion as a notifiable condition by Section 6 1(c) of the Health Act, similar to conditions such as cholera, has been a major deterrent in both sharing of information by the health care provider and provision of services because of fear of being publicized. Such a restriction reveals the extent to which the available sources of information are suppressed by the illegalization of abortion and associated promotion campaigns.

3.4 East African policies influence on Kenya

Compared to some of its neighboring countries, Kenya is more stringent on laws regarding safe abortion. As a signatory and a member of the East African Community, Kenya is significantly influenced by the regional policies as well. The East African Community Sexual and Reproductive Health Rights Bill of 2017 is one of the regional influences with significant impact on the legal/illegal aspect of abortion in Kenya. This recognizes one of the aspects that promises to improve the legal and policy situation of abortion – the Maputo Plan of Action. It emphasizes the need for comprehensive sexual reproductive health services guided by laws for operationalizing the policy. Although Kenya lacks an operational guideline in accordance to part III section 15 of this bill, the policy requires partner states to comply with its provisions. On termination of pregnancy, the section states that partner countries have a mandate to protect and facilitate a woman’s reproductive rights by permitting abortion based on the recommendation of a trained medic.

A review of existing literature proves that irrespective of the legal status of abortion, that does not change the likelihood of a woman seeking abortion for an unintended pregnancy. A relative comparison of the Kenyan situation with countries that have legal support structures for safe abortion shows that such a provision only increases the likelihood of unsafe practices. Therefore, laws and policies for the facilitation of safe abortion in a country should be viewed from a positive perspective.

On 23rd May 2016, the publication of proceedings of Community and Policy Dialogue on Unsafe Abortion in Kenya which drew participants from medical practitioners, experts in the reproductive health, legal practitioners, government agencies and victims of unsafe abortion recommended the following:

i. Revisiting, enacting and formulating of laws and guidelines including international ones such as Maputo Protocol’s reservations on Article 14(2)(C), to provide and support availability and accessibility of safe abortion services as permitted by the constitution without discrimination, victimization or stigmatization of those seeking the services.

ii. Reinstating of the 2012 standards and guidelines on reducing maternal mortality and morbidity from unsafe abortions by the Ministry of Health as well as development of their implementation work plan.

iii. A review of various policies and laws that prohibit abortion by Parliament to give way to the development of a safe abortion delivery framework.

iv. Government to provide a policy that increases budgetary funding for supporting safe abortion among other associated services such as comprehensive sexuality education.
4.1 The Mapping of SRHR Stakeholders

The purpose of this study was to reach out to as many stakeholders as possible whose mandate directly or indirectly influences the abortion discourse in Kenya. Identifying all the key players was an important goal of this research as it was important to give a clear picture of the resources supporting the agenda as well as those opposing it. Various stakeholders were mapped falling under different categories such as non-governmental/community-based organizations, alliances and networks, the health institutions/health care providers, faith based organizations and legal networks/practitioners. Depending on the categories, these players provide a range of services with their reach extending from national, regional to county level.

Almost all stakeholders mapped in this study provide a component of SRHR service in the country. At the national level, African Medical and Research Foundation (AMREF) works to promote access to reproductive health services and information among young people including access to maternal health care, family planning services and eradicating harmful cultural practices that affect the health of girls and women, through training, health systems strengthening and health financing. Planned Parenthood Federation Kenya is the other organization with a nation-wide coverage. Its primary agenda is to support partners with financial and technical assistance in promoting safe abortion across Kenya.

Most of the identified stakeholders were either regionalized or county specific. For instance, the Medecins Sans Frontieres (MSF) Kenya covers the Eastlands area in Nairobi County with a focus on making referrals and linkages. The African Women’s Development and Communication Network (FEMNET) operates in three counties namely Migori, Homabay, and Tharaka-Nithi where they conduct policy advocacy on SRHR issues while increasing access through referrals and creation of awareness through appropriate SRHR education. The Centre for Reproductive Rights (CRR) Kenya’s scope is limited to Nairobi County with its primary role in the abortion discourse being advocacy for women’s rights, provision of legal support and SRHR information through education. IPAS Africa Alliance operates in 7 counties including Vihiga, Uasin Gishu, Kakamega, Busia, Bungoma and Kiambu in the provision of Health Care Providers (HCPs) training on abortion legalities, values, and service delivery, provision of abortion/reproductive health commodities or supplies/strengthening health systems, and advocacy for the same.

The healthcare institutions and providers are an important grouping of stakeholders’ influential in the provision of SRH services as a women’s right. They are spread across the country providing a range of services including post abortion care, abortion services, and referrals. Some of the key ones include Marie Stopes; Family Health Options Kenya (FHOK) is also a major stakeholder in the SRHR operating in Siaya, Kakamega, Nairobi, Mombasa, Nakuru, Kiambu, Nyeri, Uasin-Gishu, Meru and Kisumu counties. Other health facilities mapped included Amua Clinics, Tunza Clinics, and VIAEN CO Medical Centre among others. Services such as provision of abortion related information, advocacy, referrals, as well as provision of certain Safe Abortion Care (SAC) and Post Abortion Care (PAC) services.

Civil societies, legal and human rights organizations identified and are actively involved in the legal and advocacy of SRHR included; Kenya Legal and
Ethical Issues Network (KELIN) operating in Western and Nyanza, Eastern and Central, as well as Coastal regions with its primary services being legal support and advocacy of SRHR as well as creation of safe abortion awareness through education. Network of Adolescents and Youth of Africa (NAYA) operating in Nairobi, Kisumu, Homa Bay, Kisii, Migori, Kajiado and Mombasa Counties also offers similar services, while National Organization for Peer Educators (NOPE) in Coastal region, East and Central areas, and parts of both Nyanza and Rift Valley focusses on awareness creation and referrals of abortion related cases. There are other players in this category such as Centre for the Study of Adolescence (CSA) in Kiambu, Uasin Gishu, Bungoma, Kisumu, and Nairobi counties whose work also includes research in addition to advocacy, referral and training of HCPs. Trust for Indigenous Culture and Health (TICAH) and Pwani Youth Netork (PYN) operating in Mombasa, Kilifi and Kwale Counties are also active in advocacy and referral. Other organizations include Dandelion Kenya in Rift Valley, Dream Achievers Youth Organization in Mombasa, Kilifi and Kwale counties, Omega Foundation in Kisumu, Matibabu Foundation in Siaya, and Daraja United Women and Youth Empowerment Organization (DAUWOYE) in Siaya, all of which providing post abortion care, referrals, advocacy or abortion services in their respective regions. Provision of abortion commodities and supplies, creation of awareness through education, and advocacy among others.

The study also identified several stakeholders with a religious affiliation that offer services influential in SRHR. One of these is the Kenya Muslim Youth Development Organization (KMYDO) in Nakuru, Kilifi, Lamu, Kwale, Mombasa, Garissa and Wajir counties plus entire South-Rift Region whose services touch on creation of abortion awareness through provision of information, advocacy, referral of cases, and education about post abortion care. In Nairobi County there are institutions providing full range of reproductive services including safe and legal abortion and affordable and reliable forms of contraception, advocacy and facilitate global strategies for improving SRHR education, and research. Others active in the pro-life campaigns in Nairobi include the Catholic Doctors Association and Pearls and Treasures in Nairobi, as well as National Council of Churches in Kenya (NCCK) across the country.

4.2 Explorations of perceptions and awareness of young men and women with regards to the subject of safe abortion

This baseline survey set out also to explore the perceptions of young men and women about the issue of abortion, unsafe abortion, safe and legal abortion. It also sought to gauge their awareness about the policies and provisions of safe and legal abortion in Kenya. Towards achieving this objective, four focus group discussions were conducted in the four FIDA-Kenya focus counties. The focus group discussions were composed of young men and women who were affiliated to some SRHR organization, CBO or CSO from the various counties. The participants’ ages ranged from 18 to 28 years of age. They all had some level of SRHR education from the affiliation with the institutions which were considered key stakeholders for this study.

4.2.1 Awareness about the subject of abortion

Participants of the FGDs demonstrated a deep understanding of the fact that abortion is technically illegal in Kenya. There was a strong understanding of the means used to conduct both safe and unsafe abortion and what the repercussions were. However, it was not very clear as to when abortion is allowed and who is mandated to offer the services. While there was a general agreement that abortion involved termination of pregnancy and removal of a ‘fetus’, there was a divided opinion on if a fetus can be considered to be a human being. Religion was cited as a huge influencer of how people in the society look at abortion. Perception about moral appropriateness of abortion is an important aspect because it serves to inform general acceptance or rejection of abortion either by an individual or by a group of persons. Such acceptance or lack thereof can determine if a person seeks safe or unsafe abortion, especially for those who need to seek funds to meet the involved costs.
The discussions revealed that cases of unsafe abortions were common in this community (You can name the community if it is unique to one group). Cases of attempted suicide upon realization that one was pregnant were also reported. A more recent case was that of a 22 year old girl who upon realizing she was pregnant attempted to induce miscarriage by taking a combination of an overdose of prescription drugs and concentrated juice. The attempt on abortion failed and by the time of this discussion she was four (4) months pregnant.

4.2.2 Awareness about where girls seek abortion services and methods used

While discussing about who the providers of abortion are, many of the participants mentioned that most health care facilities provided post abortion care. The participants were also aware about other facilities that provided safe abortion services. However, there was general consensus that unsafe abortions that were carried out through several means including visiting back street clinics or buying over the counter pills was common. One participant said:

“I know of a guy who is only a call away and he usually delivers the pills to your place of convenience. He charges 4,000 shillings for the pills.” (Participant, FGD 2).

Another one also noted that:

“Pharmacists also sell over the counter abortion drugs to young girls…” (Participant FGD 3).

“Using over the counter pills, both young girls and mature women also use different chemical agents or sharp objects to induce abortion. Such women employ dangerous methods like drinking large amounts of undiluted juice; taking highly concentrated mixtures of tea leaves, aloe vera and mwaruabaini (neem); taking overdose of prescription drugs including anti-malarials; even chewing high amounts of Khat; injuring the fetus with sharp objects or taking overdose of prescription drugs are pushed by lack of cheaper and better alternatives. Management of most of these cases of unsafe abortion were reported to eventually cost much more in medicals bills than it would have costed to pay for safe abortion.”

4.2.3 Cost of abortion

Many of the Participants agreed that the cost of abortions may vary depending on where one seeks it from and the means of doing it. They mentioned that for the abortion procured at Marie Stopes and FHOK the cost could be around KES 3000 to 10,000. There was agreement that most young girls and women who resort to using crude and unsafe methods including injuring the fetus with sharp objects or taking overdose of prescription drugs are pushed by lack of cheaper and better alternatives. Management of most of these cases of unsafe abortion were reported to eventually cost much more in medicals bills than it would have costed to pay for safe abortion.

4.2.4 Reasons why young girls and women may procure an abortion

This turned out to be an interesting discussion with factors such as, trying to maintain ones perceived uprightness and dignity, a woman not feeling ready for a child, issues of maintaining family honor, financial instability, emotional or mental instability due to shame, guilt, anger, and stigmatization being cited as potential reasons for pushing individuals to opt for abortion. At the centre of each of the reasons given, was the issue of unplanned pregnancy. A Participant during the Mombasa FGD narrated how her cousin was forced by a brother to induce an abortion. In part of her response she said:

“His argument was that he did not want her mother traumatized by another case of pregnancy considering the fact that we had just lost our sister in the process of terminating her unwanted pregnancy.” (Participant FGD 1).

Another important trigger of abortions was breakdown of relationships once the man realizes that a girl is pregnant.
“Some men deny the pregnancy and the woman is left with no option but to terminate it.” (Participant FGD 2).

This is a reflection of the social pressure and the kind of dilemma that women find themselves in, thus pushing them to procure an abortion.

4.2.5 Attitudes of health care providers (HCP) when confronted with an abortion request

The Participants reported that most of the HCPs were friendly and very helpful by either providing abortion services or information on abortion. In most cases where HCPs were not in a position to offer abortion services, they would refer the patient to a facility that offered such services. It was also reported that most of the HCPs would keep patient’s information confidential. One Participant said:

“...Someone (I know) went to Marie Stopes and their services were very friendly...” (Participant, FGD 2).

Another one said:

“I was involved in a project run by Marie Stopes that involved promoting access of abortion services to underage girls through referrals. The HCPs in all the clinics where I took the girls were very friendly. They started by counseling the girls and taking them through what the procedure would involve and some of the risks involved. They also do follow ups on their clients through phone calls and offer post-abortion counseling.”

What was agreeable among participants was that abortion is allowable if the pregnancy compromises the health of the mother. However, there were varied opinions on what is really meant by good health. Some felt that good health covers mental, physical and social well-being while others felt that it had a much narrower scope that includes physical and at-most mental well-being. The above responses show that there is a lack of clarity about what the constitutional, legal and policy frameworks of Kenya are concerning the issue of abortion.

4.2.6 Awareness about constitutional, legal and policy frameworks on abortion in Kenya

The Participants had conflicting opinions on whether or not provision under Kenyan legal and policy frameworks allows or prohibits abortion. One participant noted that:

“The constitution in Article 43 states that everyone has a right to health care services including reproductive health. Abortion services and aftercare is a reproductive health service. This contradicts with Article 26 that tends to restrict the provision of abortion services.” (Participant, FGD 2)

One of the participants retorted:

“I think abortion is allowed but in certain conditions. When the life of the mother is at risk, a doctor is allowed by law to make a judgment if abortion is necessary ...” (Participant, FGD 1).

What was agreeable among participants was that abortion is allowable if the pregnancy compromises the health of the mother. However, there were varied opinions on what is really meant by good health. Some felt that good health covers mental, physical and social well-being while others felt that it had a much narrower scope that includes physical and at-most mental well-being. The above responses show that there is a lack of clarity about what the constitutional, legal and policy frameworks of Kenya are concerning the issue of abortion.

4.2.7 Views about what other members of family and society feel about the subject of abortion

At this point also, the views of the Participants varied, with some for and others not for abortion. Others gave comments regarding the need to have safe and legal abortion which should be accompanied by education, awareness about abortion complications, family planning and contraceptive use before one gets into a situation of an unplanned pregnancy, and also counseling and provision of alternatives, if one is to carry a pregnancy to term rather than aborting. Others gave their opinions as influenced by their religion, while others justified the need for abortions by mentioning the kind of physical, mental, socio-economic factors that may seem to justify the act.

“I support abortion and it should be accompanied with family planning options to avoid repeat abortion and if the life of the mother is in danger. Because abortion is like an emergency and...
one can’t be having an emergency every day.” (Participant, FGD 1).

“There are people who oppose abortion completely; they consider abortion as evil and then there are some in the community who even know where the services are offered.” (Participant FGD 1).

“…Christians believe abortion is a sin.” (Participant FGD 2).

“I don’t support abortion in general, but in the cases of complications or contraceptive failure.” (Participant FGD 3).

The participants argued out their divergent views regarding the issue of abortion and no consensus was arrived at as everyone kept their own opinions.

4.2.8 On stigma and discrimination

The participants spoke about issues of stigma and discrimination that is faced by young girls and women who have an unwanted pregnancy. One of the Participants mentioned that fear of discrimination turns out to be a driver of unsafe abortions in the community.

“...In our cultural and religious society, women who commit abortion are disowned by their families.” (Participant FGD 1),

“...Because of stigma and how community will perceive them, some women would choose to go to quack doctors to access these services...” (Participant FGD 2).

Women who carry unwanted pregnancies suffer from shame and guilt and subsequent discrimination from family and friends.

One of the respondents in this study was quoted saying that:

“The country enacted the Choice on Termination of Pregnancy law but women still have unsafe abortions because of stigma and lack of information. So even if the law allows for safe abortion, the stigma that is often associated with it will deter women from seeking such services.” (Participant, KII, Kisumu).

4.2.9 Participants recommendations regarding the issue of unsafe abortion

Participants seem to be unanimous about the fact that it is important to tackle the problem of unsafe abortions. One of the Participants mentioned that;

“For safe abortion, the law should limit health to just physical health of the mother because if a lady walks into a facility seeking abortion, just because, with no health reason, she should not be allowed. She should be given other options such as financial help when she gives birth. The woman should be counseled to gain confidence to carry the child to full term.” (Participant FGD 1)

While another one also said:

“Provide solution after the abortion, giving family planning and also counseling.” (Participant FGD 2).

Others reported that it is important to provide a solution after an abortion has taken place.

On the one hand, it was deemed important for women to be provided for with healthy alternatives before the need for an abortion arises. These were seen to be, such as, provision of sexual education, family planning, contraceptive usage, accessible sexual and reproductive health services among others. On the other hand, it was also reported that it is crucial to provide women who have an unwanted pregnancy, comprehensive counseling and psychotherapy to assist them to adjust to the pregnancy, and in case they opt for an abortion, then safe services should be provided, as well as post abortion care. In the same breath, provision of alternatives in case a woman is not able to raise that child, such as socio-economic empowerment, adoption services within or outside the family set up, among other options should be explored and provided.

4.3 Views of human rights, legal and policy stakeholders

Stakeholders in human rights were targeted because of the role that they play in ensuring that the government upholds and implements all the human rights international agreements it is signatory to, including the Maputo Protocol and the WHO
standards and guidelines. They are also proactive in championing for comprehensive implementation of all provisions of the Kenyan constitution rights, including Article 26 (4). The complex and sometimes controversial interpretation of the constitutional rights around termination of pregnancy has a great bearing on the slowed progress towards the achievement of the rights and equal treatment of women in Kenya.

It is for this reason that this study targeted human rights organisations to gain a deeper understanding of the prevailing situation around this topic in the modern Kenyan society.

The findings of this study revealed that human rights organisations provide a range of services. For instance, a key stakeholder emphasised that:

“FEMNET works a lot on issues that support women’s rights and that encompasses having discussions and advocacy around SRHR.” (KII SRHR 1).

This is in line with the work of another organisation that stated that their primary work is in policy engagements with policy makers at government ministries, departments and County governments. In fact, one key informant participant quoted that:

“KELIN is currently being involved in the validation of the current MOH Post-Abortion Care guidelines.” (KII SRHR/Legal 2).

The organisation was actively involved in the development of the suspended MOH Standards and Guidelines as well as many other policy processes. This role closely interrelates with advocacy of human rights which also emerged as a major type of service. Some of the activities mentioned by a significant proportion of the participants include sensitization and civil education on human rights. Other than this, the study recorded other organisations dealing with provision of legal representation such as KELIN.

The key informant stated that:

“KELIN provides legal assistance to women and health care providers who are charged with abortion-related offences. Under the legal support network, we offer legal representation in court for women and HCPs who’ve been charged…” (KII SRHR/Legal 2).

Finally, capacity building and training of youths was noted as one of the main services offered by these organizations as ascertained by one of the participants who stated that:

“We do training for young girls and women to empower them with knowledge on legislative frameworks around abortion for advocacy.” (KII SRHR 5).

The various participants in this study indicated that their organizations had a national reach because they push for policy changes at the national level. However, there were others whose operations were regionalised in specific areas, such as, Eastern and Central Region, Rift Valley, Coastal, Western, Nyanza and Nairobi. Moreover, a significant proportion indicated that they only operate in specific counties, such as Migori, Tharaka-Nithi and Homabay, Mandera, Isiolo, Wajir, Marsabit, Migori and Lamu.

Often, cooperation parallels in the scope of work among organisations is not a rare thing when it comes to human rights services in an area. It is one of the reasons almost all the participants expressed awareness of other stakeholders advancing similar agenda as theirs – supporting and advocating for safe and legal abortion. For instance, some of the participants quoted that:

“We work with institutions such as Womankind, MYONET, KASNET, NewLife Mission in Kajiado, among other CBOs and CSOs in the counties...” (KII SRHR/Legal 4).

The linkages in their operations reveals that advocating for safe abortion has gained speed in the contemporary era in Kenya.

4.3.1 Reviewing Kenya’s constitutional position on abortion

Results arising from this study shows that the Kenyan constitution has a provision that allows for termination of pregnancy once certain conditions are satisfied. For instance, the findings reveal a deeper understanding of the legal and policy frameworks governing abortion in Kenya.
In 2015, KELIN published a document that highlights all the laws and policies at the county, national and international level that discusses abortion. At national level we have the Constitution Article 26 (4) that allows for abortion on certain grounds. There is also the Penal Code (Section 158-160) which criminalizes abortion, MOH National Guidelines on Management of Sexual Violence that provides rights of a sexual survivor including termination of pregnancy, Post-Abortion Care Guidelines, MOH National Guidelines for Quality Obstetrics Care, and Professional Codes of Conduct that guides HCPs in providing abortion services.

At the International level there is the Maputo Protocol, WHO Safe Abortion Technical Guidance Policy Document of 2012, FIGO Initiative for Preventing Unsafe Abortion and the General Comment No.2 of the Maputo Protocol. The challenge now is that each county is regulating abortion in its own way. One of the Participants stated; “We have been tracking how all counties develop their policy/laws, we have only missed two counties that have enacted laws in the last two years. We have been following how Kilifi, Makueni, Nakuru and Nairobi are addressing the issue of abortion in their health act or bill.” (KII SRHR/Legal 2).

Another participant added to this by saying that; “Solidarity for African Women’s Rights (SOAWR) has been in the front line especially in pushing for the ratification of the Maputo Protocol especially sections around safe and legal abortion...” (KII SRHR/Legal 2).

4.3.2 Human rights and legal challenges in the safe abortion discourse

Stakeholders in the human rights sector revealed that executing their mandate especially in the rights of women including abortion services faces numerous challenges. In this case, while they strive to push for progressive policy changes, this study found out that regressive policies at the county level are threatening to roll back the achievements so far. Based on one of the Participants, some counties have enacted retrogressive laws that contradict the constitution.

“For example, under Kilifi’s County Health Act, abortion is allowed only in emergency situations, which is contrary to what is provided for in the Constitution.” (KII SRHR/Legal 2).

The second highlighted challenge is lack of proper understanding of the constitution by the police. A response from the various interviews showed that the police are yet to appreciate that the constitution allows sufficiently wider grounds for safe abortion.

“Today, KELIN receives a lot of cases which swiftly get kicked out of court mostly because of insufficient evidence. The mere fact that law enforcers have no clear understanding of what is legally permitted or prohibited within this scope has left many stakeholders harassed or wrongfully detained, and this interferes with the delivery of services.” (KII SRHR/Legal 2)

Human rights organisations are very categorical when it comes to the rights of women including equal treatment especially on issues regarding abortion. However, the results from the study shows that they are concerned with the chronic lack of information about the legal situation of abortion in the country. One KII retorts; “Due to stigmatization and criminalisation by the Acts, it has particularly become very complicated to disseminate abortion related messages as revealed by the recent wrangles between some of the service providers, Marie Stopes, and authorities.” (KII SRHR/Legal 3)

4.3.3 SRHR/Legal stakeholders perspective on religious role in the abortion discourse

Several SRHR/Legal stakeholders felt that religious views have been contrasting with the views and opinions of human rights organisations resulting in a lack of understanding on the way forward to address unsafe abortions in Kenya. While the latter have persistently been pushing for relaxation of laws to allow for abortion on a variety of grounds in the country, the latter has been calling for a total ban on abortion and related services. Therefore, it is true that religion is unsupportive of the abortion
promotion agenda. One of the participants, KII, Nakuru stated that;

“The church is completely against comprehensive SRH and this includes abortion. It may not be useful to work with the church in this regard, but rather put up a discourse that is well framed in order to convince legislature and some religious people.” (KII SRHR/Legal 3).

In fact, the finding is that the church is completely against comprehensive SRHR and this includes abortion. This also explains why religious and personal convictions of doctors have also been highlighted as serious factors that may deter them from providing abortion services. Irrespective of this, due to the rights of every person as stipulated by the WHO guidelines, a HCP is therefore, allowed to have a conscientious objection.

“A doctor can object to any medical procedure based on his personal beliefs or conviction, or morals or religious beliefs.” (KII HCP 1)

Despite this, the requirement in law (WHO standards) is that the HCP must do an effective and timely referral in such a case to avoid this being a deterrent. However, few of them conform to this provision in the country today.

4.4 Health care providers perspective on the issue of safe abortion

Health care providers’ interviewed in this study spoke about the need to provide girls and women access to SRHR services which may sometimes include safe and legal abortion services. The restriction on the law and policies on abortion lead to more unsafe abortions taking place because the girls and women will seek it from any source. A KII with a HCP who worked at the GVRC of the Nairobi Women’s Hospital in Nairobi mentioned that the hospital receives many girls and women who come in for treatment resulting from abortion complications. One of the doctors mentioned the following:

“Some of the complications we encounter result from girls and women who have inserted foreign objects in their vaginas and forcefully terminated their pregnancies. Some go to the back street or quack doctors who provide the services and tell the girl/woman to go to the clinic when they feel that they are experiencing some problems (complications)” (KII HCP 1).

The centre offers PAC services to girls and women that suffer from complications of unsafe abortions among others.

According to this study, the main factors motivating women to seek abortion services were unplanned or mis-timed pregnancies. One HCP stated that;

“Crisis pregnancy / unintended / mis–timed pregnancy irrespective of a woman’s age or if the pregnancy was a result of coerced or unprotected sex.” (KII HCP 6). He continues to describe some of the cases that he sees at the hospital. This is what he said;

“At the hospital’s GVRC we get many girls and women who have been defiled, raped and some cases of voluntary abortion request. For the girls and women defiled, we offer comprehensive treatment in terms of medical and psychosocial support. We work with many counselors who support this. Medically, the girls and women will be provided with post rape care, especially when they come before the required window lapses. They are given antibiotics, anti-retrovirals, pain killers, medication to avoid pregnancy, treatment of wounds, tears are sutured among other things.”

Some of the complications of unsafe abortions that he had seen at the clinic included fistula, bleeding, shock, sepsis and even death. The centre serves girls and women from Nairobi and even other neighbouring counties.

“...Majority of our clients are from the slum areas of Nairobi or low socio-economic areas, especially Kibera, Dagoretti and Kawangware and sometimes they may come from as far as Naivasha and other counties.” (KII, HCP 1)

Regarding the issue of permissiveness in the Kenyan law about abortion, one HCP said the following:

“Abortion should be legalized in only special cases. These can be raped women, mentally handicapped, health risks, life risks situations.” (KII HCP 2).

HCPs added the importance of having clear mechanisms embedded in policy that ensure clear identification of these needy cases;
“A clear vetting on who should get the procedure is required. However this should be made extremely clear, such that there should be a checklist that measures this. It should be standardized and must define clearly the specific identification of such cases, who should do it, and where.” (KII HCP 1)

4.4.1 The cost of procuring an abortion in Kenya

All the HCPs interviewed mentioned that the cost of procuring an abortion in Kenya varies depending on the location, the type of health facility providing the service, the socio-economic status of the client seeking the service as well as the gestational period of the pregnancy at the time. Big private hospitals charge a higher fee to procure an abortion while smaller clinics are cheaper. Abortion at early gestation is cheaper than at late pregnancy as suggested by this HCP:

“It depends, it can be as cheap as a few hundred shillings and expensive as 100,000 Kenya shillings depending on where the health facility is and the gestational age. Big private hospitals are expensive and smaller clinics are relatively affordable. The KMDP has fee guidelines for various conditions including abortion, the fee differs based on gestational age i.e. for early pregnancy—below 13 weeks (10,000kshs and below) and mid-pregnancy (50,000 and above) (KII HCP1)

It is evident that the cost of safe abortion in Kenya is high and beyond the reach of the majority of girls and women of low socio-economic status who are in need of the services. The high cost of safe abortion services is one of the biggest deterrents to access of SAC which leads women to seek unsafe abortions resulting in the high mortality and morbidity witnessed in Kenya. One HCP noted that;

“The high cost of safe abortion services in Kenya implies that abortion is legal and accessible to the rich and illegal and inaccessible to the poor.” (KII HCP 4)

Abortion services in Canada are provided free of charge in all public health facilities. Ethiopia, an African success story in provision of SAC and PAC has witnessed reduced costs and increased access of abortion related services as a result of opening up all public health facilities to provide abortion services and training HCPs at all levels of the healthcare system. There is need for the government to consider opening up public health facilities to offer SAC services in an attempt to reduce the associated costs and improve on accessibility of these services. The government should consider subsidizing the cost of SAC services or including the cost of SAC under the National Hospital Insurance Fund (NHIF) supported services as indicated in the following quote “Safe abortion should be available to all women and should be catered by NHIF—women should be able to freely walk into any accredited facility and get the service.” (KII HCP 5)

From this study, it was noted that majority girls seeking abortion services were referred by their friends or relatives, community health workers who have had the same service. One HCP observed this “Most of my clients have been referred to my clinic by their friends/relatives, and by Community Health Workers (CHWs). Since, I cannot openly advertise for the services, I have indicated ‘Pregnancy Crisis’ in the list of services the clinic provides.” (KII HCP 6). It was also reported that HCPs cannot openly advertise abortion services for fear of harassment and arrests by the police.

4.4.2 HCPs reiterate on the need to have standard guidelines, clear laws and policies to tackle unsafe abortion

All the HCPs interviewed indicated however, that there seems to lack clarity in the Kenyan law which leaves room for different interpretations concerning provision of SAC. Although majority of the HCPs agree to the legality of provision of SAC services, there is a general agreement that the law requires review to provide clarity and eliminate chances of its misinterpretation based on personal, cultural and religious perceptions, views and beliefs. Moreover, they second the reinstatement of standards and guidelines.
The HCPs reiterate the need to have quality services provided to girls and women in need of this service in order to tackle the maternal morbidity and mortality rates. He adds;

“This should be made clear so that not all HCPs should have the authority to procure abortion. Also a HCP must be trained for safe and legal abortion care.” (KII HCP 2)

Another strategy that was mentioned by the HCPs to tackle the problem of unsafe abortion included the need to reinstate 2012 Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion and also the debate of the Reproductive Health Bill. One of the HCPs said:

“The Reproductive Health Bill should be reinstated and the section on abortion really looked at in detail. This should be strengthened with very good justifications provided.” (KII HCP 3)

For instance, another HCP interviewed in Nairobi stated that:

“The standards and guidelines are necessary for the implementation of Comprehensive Abortion Care. For example if a HCP wants to provide abortion services, then how do you do it? How do you handle complications? The guidelines should be in place. Without guidelines, abortion services will be provided in an unstandardized manner.” (KII HCP 4)

Some of the health care providers mentioned that as much as some providers advocate for safe and legal abortion, this will not get rid of long term abortion complications. He said the following:

“Abortion, whether done voluntarily or not will always have women experience long term consequences. These may include depression, stress, infertility relationship/social complications etc. It is, therefore, important for women to understand these even as they are making the decision to have an abortion...” (KII HCP 1)

Some of the HCP KII s that provide SAC and PAC stated that;

“The standards and guidelines help the health worker to determine whether that particular case is applicable to an individual in terms of gestational age, physical and psychological health of the woman/girl. It sets parameters for the provision of abortion care. If providers do not have these skills it’s very risky. A health worker needs guidelines to conduct an abortion by using the correct technology, equipment and drugs.” (KII HCP 4)

“The act of withdrawing the guidelines means that we are restricted in service provision. The withdrawal of the guidelines was as a result of the rationale that the guidelines were being misused and the religious groups argued that the guidelines were not morally okay. This has led to an increase in unsafe abortion because health workers are doing it in unsafe conditions...” (KII HCP 7)

This reflects the argument by some of the KII participants in both Mombasa and Nairobi that;

“The interpretation of the law is sometimes interpreted to mean that all abortions are illegal and so the service providers feel threatened when providing these services.” (HCP KII 4)

Another one went on to say that;

“In Kenya, there’s no clear policy that the health care professionals can follow and the interpretation of the existing policies is left to the providers’ discretion.” (HCP KII 4)

During an interview, one of the HCPs noted;

“The reason there is so much stigma among the HCPs and the entire community is because of misinformation, inaccurate information or general lack of information on safe abortion. This affects the government systems, politicians, the health care system, churches and religious groups and the community. The only way to change this is to create awareness at all levels. Only the truth can redeem the situation; to preach the truth to everyone about safe abortion.” (HCP KII 5)
4.5 The issue of safe abortion and religious views

4.5.1 Religion and the constitutional provisions on safe abortion care

The church and religious organizations have been very vocal to oppose any form of SAC services offered to women and girls in Kenya. This has been a contentious issue, not only in Kenya where the laws are somewhat prohibitive but also in other developed countries even those that have permissive laws on abortion. There is a common belief among all religious organizations that life begins at conception and that procuring an abortion is killing. One of the representatives from NCCK spoke categorically about the biblical principles with regards to life of the unborn. She said the following:

“I do not support abortion and as a representative of the church, I will speak about the views of the church and also those who believe in God. The views of the church are very simple. We are governed by the word of God, this includes all the organizations under NCCK. We believe that God’s word is God-breathed; useful for teaching, correction, rebuking and training. (2Tim 3:16).

If the Christians are going to have any stand whether it is medical, social or economic it should be governed by the Bible. Any ungodly thing that is done even by a Christian doesn’t negate the word of God. People should understand where the church is coming from because their views are from God. The church doesn’t want to disobey God.” (KII Christian Leader 1). She mentions that the word of God is clear about killing a human being.

“In the book of Exodus, there is a commandment that states ‘Thou shall not kill’. If the word of God says this, then the Christians have to obey. If we fail to obey, we will be in trouble with God.”

These views were not only mentioned by Christian leaders but also by Muslim leaders who participated in this survey. One Muslim leader said;

“Abortion is against Muslim faith and values. It is a sin. The Quran and the Bible are supreme, higher than constitutional laws. Our organization is pro-life, God gives life and no one should take it away.” (KII Muslim Leader 2). However, he added that abortion;

“Is against Islamic teachings. It should not be done unless the physical health of the mother is at risk.”

He adds that some kind of permissiveness should be allowed where the health of the mother is in danger. The Muslim leader acknowledged that such strong beliefs are deeply entrenched in Kenya because Kenyans are majorly religious. He mentions that this leads to the fact that many Kenyans, hence, will not even want to be involved in the discourse on abortion. He said;

“The result of this, is people who believe that abortion, whether safe or unsafe is murder and many of them would not even be involved in any discussions surrounding safe abortion service delivery. These beliefs lead to stigmatization of women seeking abortion services as well as HCPs hence affecting service delivery.”

It was clear from the interviews and discussions conducted that religion had a great influence in the withdrawal of the 2012 Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion. Many pro-life groups which are vocal opponents of the safe abortion agenda are supported and funded by the church. According to the church, abortion is a sin that should never be tolerated at any level in the society.

“If you talk about safe abortion, is there safe killing? Whether you kill an unborn baby safely or unsafely, the end result is that ‘you killed:”’ (KII Christian Leader 1).

Concerning the Kenya Constitutional provisions, the Muslim cleric indicated that they are aware that the constitution partially legalizes abortion. He noted the following:

“In the confines of the constitution, abortion should be done only under the conditions provided for. It should be done only when the mother’s life is at risk. Other aspects of health such as social, psychological/mental should not be considered. Those should be addressed through counselling…”

According to a key informant Muslim cleric from Nairobi, the mother’s life at risk should be the only factor to consider before procuring an abortion. There is, however, skepticism that many of the HCPs are misinterpreting these laws for their own financial gain.
“Some health care providers interpret and use such provisions for their own financial benefit, and this should not be allowed... Abortion services have been commercialized...”

4.5.2 Tackling abortion through prevention of unwanted pregnancies

Religious leaders were keen to provide alternative options regarding the issue of abortions reiterating that the discourse should not be about safe abortion but more on the preventive measures against unwanted pregnancies. According to the Muslim cleric interviewed in this study, more emphasis should be provided in preventive teenage pregnancies through comprehensive sexuality education. He says;

“The focus should be on providing comprehensive sexuality education and promoting uptake of family planning methods... If we could only prevent teenage pregnancy through comprehensive sexuality education, abortion will not be an issue for discussion. Providing abortion services is a reactive and not pro-active measure...”

This implies that prevention of unwanted pregnancies would be more acceptable than providing safe abortion care itself.
5.1 The situation analysis of safe and unsafe abortions in Kenya

The literature review of several peer reviewed reports and documents from SRHR organizations revealed that Kenya is one of the countries with the highest prevalence of unsafe abortions leading to high mortality and morbidity rates. The KDHS 2014 revealed that the total fertility rate is highest among women aged 20-24 years old. This is the age group that carries the heaviest burden of unwanted pregnancies and subsequently unsafe abortions. The abortion rates were shown to almost double with increase in age from adolescents (15-19 years) to women aged between 20-24 years (from 38 per 1000 women to 76 per 1000 respectively), before declining slightly to 69 among 25–29 year-olds. The lowest rates of abortion were reported between ages 45-49.

One of the more recent studies that investigated the incidences of abortion, revealed that in 2012 alone, 464,000 induced abortions occurred in Kenya, translating to a national rate of 48 induced abortions per 1,000 women aged between 15–49 years and an abortion ratio of 30 per 100 live births. The study continued to report that about 120,000 women received care for complications of induced abortion in the various health facilities around the country. At the same time, it was established that about half (49%) of all pregnancies in Kenya were unintended, with 41 % of the unintended pregnancies ending up in abortion. It is estimated that cases of women procuring multiple abortions are common. In a national survey examining the history of previous induced abortion among 1,378 young women aged 12–24 years who sought abortion services in 246 facilities, it was estimated that 9% reported to having procured an abortion previously. These trends, bearing in mind a good number are unsafe, leads to high levels of maternal deaths. The WHO reveals that in East African countries, 18% of all maternal deaths result from unsafe abortions. Research has shown that adolescents are more vulnerable to severe complications from clandestine unsafe abortions than older women. In 2013, it was estimated that 10–19-year-olds accounted for 17% of all women who sought post abortion care in public facilities, and that 74% of the moderate or severe complication cases were among this group, partly because of their use of unsafe methods or seeking help from less skilled or ill equipped health care providers.

The problem of unwanted pregnancies is not only a problem among young unmarried women but also among married women. KDHS (2008/9) reported that 43% of married women pregnant at the time had unintended pregnancies. These high rates of unintended pregnancies are as a result of demonstrated poor uptake of contraception especially among populations most at risk of unintended pregnancies such as adolescents and young women.

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38 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4546129/pdf/12884_2015_Article_621.pdf
Complications of unsafe abortions put immense pressure on an already strained healthcare system costing the government huge sums of money. The main challenge facing efforts to provide proper services to women seeking abortion in Kenya is unfavorable legal and policy provisions. Any intervention designed to manage this problem should be fully aware that the legal and policy frameworks are restrictive to the provision of safe abortion and give more efforts to prevention of unplanned pregnancies. Moreover, it is important to ensure that the public is well informed about issues of abortions. Supporting health facilities to care for patients is also paramount in helping avoid needless and permanent physical and psychological damage that is related with unsafe abortions.

5.2 Challenges and barriers to accessing safe and legal abortions in Kenya

One of the main barriers in the achievement of safe and legal abortion is the issue of moral acceptability of abortion as a solution to an unwanted pregnancy. This results in controversy surrounding the debates for and against abortion. On the one hand, arguments raised opposing abortion are not as such supported by a certain sort of logical proof but are based on some religious beliefs and the belief that life begins at conception.

It is on the basis of this that opponents of abortion seek absolute criminalization of abortion on the one hand and for its liberalization in all circumstances on the other.42

On the contrary, proponents for safe and legal abortion argue that life does not necessarily begin at conception while the opponents of this argue otherwise. Studies have challenged the assertion that life begins at conception arguing that it is challenged with viability. The viability of a foetus starts at a later time of the period of the pregnancy, around the 22nd to 26th weeks of pregnancy before birth and therefore we cannot talk about life at the time of conception.43 These proponents portend that women have rights over their own bodies and hence the right to abortion. The basis of this argument are autonomy, bodily integrity and self-ownership which is stipulated in the human rights of women as enshrined in the constitution as well as in international human rights instruments.

Challenges facing efforts to eradicate unsafe abortion can be summarized as:

Kenya is currently facing one of the most challenging times regarding the discourse and provision of safe abortion services. One of the main challenges that influence young men and women is a general lack of awareness among the youth about the legal and policy frameworks regarding provisions of abortion in the Kenyan constitution. The findings of this study show that only a minority of the Kenyan population know about the exemptions in the constitution because of lack of capacity building and education. It is due to this that some of the targeted organizations of participants in this study focus on creation of awareness on the subject of safe abortions in the country.

The costs of safe abortion services are too high for many girls and women seeking those services. After the withdrawal of the 2012 standards and guidelines for reducing morbidity and mortality related to unsafe abortion in Kenya, only private health facilities offer safe abortion services albeit in secret for fear of victimization and harassment. This has made access to safe abortion too expensive and out of reach for most girls and women in need of the services. The above sentiments were corroborated by literature review that revealed that illegalization of possession or supply of drugs and instruments needed to provide safe abortion forces involved costs to go high and beyond the reach of most Kenyans – Kshs 6,000 - 15,000. This exposes

Kenyans to unsafe services which are mostly conducted through self-prescription or in the hands of unqualified and ill-equipped individuals. Unfortunately, unsafe abortions come at a big financial and physical cost. For instance, estimates report an average of up to Kshs 432.7 million is annually spent to treat complications arising from unsafe abortions in Kenya. Such expenses inform of the high expenses that trickle down to the victims due to the restrictive nature of accessing safe abortions in Kenya.

The religious and traditional beliefs of many Kenyan's seem to be firmly against any form of abortion. Kenya is a highly religious country with religious beliefs being deeply entrenched in the society. This research established that constructed social norms don’t allow or support abortion. In religious and social circles, it was also acknowledged that the problem of unwanted pregnancies is increasing and there might be need to find more long term solutions to prevent unwanted pregnancies rather than provision of safe abortion.

Kenya’s political environment also offers challenges in the unsafe versus safe abortion discourse. The debate about abortions is highly politicized and any efforts to develop more supportive legal framework is always faced with aggressive political debates.

A lack of clear guidelines and policy frameworks to tackle unsafe abortion was reported to be a big problem in the Kenyan context. In November 2018, the KMPD issued a statement banning the provision of abortion services by one of the main clinics that operates in Kenya. This study revealed that as a consequence of the conflicting legal aspects, safe abortion services were not easily accessible to women and girls who needed them. Unfortunately, this shortage of equipped facilities offering such services leaves gaps that allow quack ‘doctors’ to take advantage and offer these services illegally and without the right qualifications.

The standards and guidelines for reducing morbidity & mortality from unsafe abortion in Kenya, which were withdrawn by the Kenyan Ministry of Health in 2013, were intended to provide guidelines for the provision of SAC and PAC. They provided for the training of HCPs on the provision of SAC and PAC services as well as devolving of these services to increase accessibility and reduce the associated costs. In this study, all the HCPs felt that the reinstatement of these guidelines would be a step towards increasing access to SAC and PAC, which will in turn reduce maternal mortality and morbidity associated with unsafe abortions. Majority of the private HCPs providing safe abortion services are currently providing these services in secrecy for fear of victimization. There is also extortion and harassment of HCPs providing abortion services by the police and other law enforcement agencies. Reinstatement of these guidelines will provide a code of conduct and protect the HCPs from harassment and extortion. The guidelines will also help ensure that there is adequate training for HCPs on comprehensive abortion care hence improving the quality of abortion care across the country. All the HCPs interviewed in this study noted that the reinstatement of these guidelines will help streamline the provision of comprehensive abortion care services, increase access, reduce cost and reduce the stigma associated with the provision of these services.

Although Kenya had made significant strides towards the improvement of maternal health especially when it comes to prevention of morbidities and mortalities arising from back-alley quack abortions, the withdrawal of standards and guidelines on reducing maternal morbidity and mortality from unsafe abortions backtracked this progress. This research revealed that having the right standards and guidelines is paramount if a country is to successfully reduce the rates of unsafe abortions and related consequences. A classic example of this is Mozambique and Ethiopia, two countries that have drastically tackled a menace that has plagued the Kenyan women and girls at a higher rate ever since the withdrawal of the 2012 guidelines.

The issue of ‘conscientious objection’ by health care providers was also reported to impede access to safe abortion services. Young women participating in FGDs mentioned that there were
cases of approached HCPs objecting to abortion and openly judging their patients. This discourages these women and pushes them to use dangerous methods to induce abortion.

The global gag on SRHR service providers and advocacy efforts is also negatively affecting efforts designed to educate, sensitize and create awareness among communities. This is reported by many stakeholders to be causing negative impacts on the health and human rights of girls and women. Based on this study, the involvement of the public, especially the young people both male and female who are a critical group of interest, is a critical step that most SRHR organizations are taking to boost their advocacy campaigns. In fact, they have raised concerns that the attacks on specific facilities offering safe abortion services conducted in the third quarter of 2018 could well have been exacerbated by the public perception that abortion is illegal in Kenya, contrary to the constitutional provision that allows for abortion on certain grounds. Although there are many organizations working as human rights or providers of sexual and reproductive health services, evidence emerging from this study shows that their efforts have been severely squashed by lack of funds following the US government slashing of international funding on various schemes.

Lobbying for safe abortion is an intensive exercise demanding maximum facilitation and support. However, Participants in this study revealed that recently, the global withdrawal of governmental funding has had a significant impact on their efforts. It comes out clearly that most of the organisations have seen their reach and scope limited by the insufficiency of funds. For instance, a participant stated that although the organization she works with has a national outlook, extending their services to the hard to reach areas has been extremely difficult. As a result of this, facing a safe abortion battle against the better funded and more vocal pro-lifers is a tough task. Despite the hard figures and facts that show that unsafe abortion has huge personal, social and economic consequences, the pro-life narrative seems to be more quickly accepted and supported. Although the African Union and other regional bodies have explicitly mandated their member states to take appropriate measures to reduce the rates of maternal mortality through programs that boost the services in reproductive health, including accessibility of legal medical abortions, the willingness to fund such programs have remained largely indifferent especially in Kenya.

5.3 Key stakeholders in the SRHR space

This research found out that many organizations and healthcare institutions are ready to challenge the legal and policy framework on abortion in the country. At the time of the evaluation, there were continuing joint efforts to push the pro-choice agenda. The high number of maternal mortality and morbidity contributed by unsafe abortions in the country seemed to be a key motivator of various partnerships between various organizations that are in favor of safe abortion. Some of the key players in advocating for and in providing safe abortions were classified as follows:

- Providers of safe abortion and post abortion comprehensive services
- Research, advocacy and awareness creation in the SRHR field
- Human rights and legal support
- Passionate individuals working in the SRHR space

5.4 Legal and policy gaps on the Status of Abortion in Kenya

The Kenyan constitution of 2010 allows for provision of abortion services albeit with restrictions. This was a first major step towards provision of safe and legal abortion services in Kenya. Kenya is a signatory to a number of international standards including the Maputo Protocol and WHO guidelines.

Although the Kenyan constitution permits abortion on grounds of saving the life of the mother or in case of an emergency, guidelines expounding and clearly clarifying what is actually legal and illegal are missing. The uncertainty has exposed
many healthcare providers offering this service to exploitation by police while many others have seen closing the services. In fact, the withdrawal of the 2012 guidelines also banned the use of some of the drugs among others. Moreover, the inadequacies in policies have complicated acquisition of proper equipment which continues to impact on the accessibility of safe abortion. The situation is worsened by the unavailability of policies and guidelines for training healthcare providers in the health care system to address the need for safe abortion. As a consequence, Kenya is in a precarious situation where, as quoted by Article 26 (4) alongside Penal Code Act 63, it is not clear what qualifications constitute a trained health professional. Moreover, the magnitude proving a life threat or emergency remains medically unsubstantiated. This informs the unwavering efforts by an organization such as FIDA Kenya and like-minded entities to bridge this policy gaps.

Rather than demystifying the negative perspectives associated with abortions in Kenya, the withdrawal of Standards and Guidelines in 2013 by authorities in Kenya simply stalled the achievements made so far. Abortion-related statistics in the county are indisputable proof that the social repercussions of policy lapse in regulating abortions are disastrous. Today, though the 2010 constitutional change brought a significant level of liberalization, the country is still languishing in a concoction of social stigma regarding abortion. Different stakeholders have been left to interpret the ground where abortion is permitted, though this has no legal or policy backing.

Kenya faces a serious constitutional debate especially in matters surrounding abortion because of legal ambiguity. While the 2010 constitution gave some exceptions, the religious sector presented as the pro-life has been actively campaigning for a total ban on abortion in Kenya. A review of the Kenyan legal framework on abortion shows apparent inconsistencies pointing to the glaring policy shortcomings. For instance, although the Penal Code section 158-160, which is prohibitive in nature has been cited by pro-life activists, the pro-choice group often focus on the exceptions permitting abortion provided by Section 4 of Article 26 in Kenyan Constitution. Moreover, the provision requiring the opinion of a trained healthcare professional fuels more contention with the religious groups who argue that the unborn remain scarcely protected by the Constitution. In response, they bring in the argument that Kenyan Constitution Article 2(5) and (6) indicates that the state is legally and bound to comply, adopt and incorporate or implement best international instruments practice related to the rights of humans. In fact, the country is also compelled to apply good faith in performing them. The emphasis is on the absolute rights of all individuals without bias on sex, age or any other grounds including before and after birth.

Such legal conflicts would have, however, been averted with comprehensive policy and guidelines that delineates where abortion is permitted.

The social freedom of the victims and the abortionists is also impacted by the stringent laws and policies. Based on the penal code provisions section 158 and 159, the court can find the victims involved guilty of murder or infanticide especially when interpreted alongside Article 26(2) of the Kenyan Constitution which states that life begins at conception. Therefore, although section (4) leaves the doctor with the prerogative of approving or disapproving an abortion based on specific grounds, the legal situation in Kenya complicates accessibility of safe abortion because the legal consequences are very costly even to the health providers. In fact, the possibility of serving jail terms is ripe in the event one is found guilty of violating this law.

Some of the major gaps identified regarding the legal and policy frameworks in Kenya include:

- Although the constitution legalises abortion on specific grounds, definition and interpretation of abortion in the Penal Code Act 63 remains a controversial and debatable issue.
- There is a gap in legal guidelines about how to determine when a pregnancy is deemed to threaten the life and health of the mother.
since this interpretation is left to the discretion of trained healthcare providers explaining the diverse interpretations.


- Kenyan constitution article 26 (4) stipulates condition for provision of legal abortion. However, the prohibitive Acts 63 section 158-160 complicates interpretation regarding safe and legal abortion.

- The law mentions a trained medical practitioner alongside the allowable limits for legal abortion but it lacks a clear description of which qualifications this HCP should have to ensure a safe abortion is carried out.

- Although the Reproductive Health Bill of 2014 section 19 (c) indicates that the mother or care giver/taker in specific cases must give consent, there is actually no clarity on what reasons the choice for an abortion on behalf of a minor should be based on e.g. rape, mental disorders among other associated reasons.

5.5 Debates among Health Care Providers (HCPs) in provision of abortion services

However, it still remains unclear how health should be defined since there are no guidelines elucidating this component. It is an inadequacy that has left stakeholders at cross-roads with some adopting the WHO definition while others do not, coupled with the misinterpretation of the laws and policies, making the situation even more complex.

To provide the necessary frameworks for the implementation of the constitutional provisions on safe and legal abortion, the Ministry of Health drafted the comprehensive Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya. This was meant to standardize the provision of safe abortion care and post abortion care in Kenya. These guidelines outlined the training requirements for HCPs providing abortion services as well as facilitated the expansion of abortion services in the public health sector so as to improve access and reduce abortion associated costs.

Unfortunately, these guidelines were operational only for a few months and were withdrawn in 2013 due to pressure from the church, religious groups and other key players who were against provision of abortion services. The withdrawal of these guidelines left a major vacuum in safe abortion service provision. The events following the withdrawal of these guidelines led to the stigmatization of HCPs providing safe abortion services as well as women seeking post abortion care due to complications resulting from unsafe abortion practices. At the same time, training for HCPs in public health care system on provision of SAC was banned, leaving private facilities and NGOs as the main providers of information on abortion and safe abortion services.

Even so, these HCPs and NGOs mainly provide SAC services in secret; and if they get vocal about SAC service provision, the consequences may include closure as was the case with Marie Stopes Kenya in November 2018. Increased costs worked towards increase in numbers of clandestine and unsafe abortions. To stem down the high rates of maternal deaths and align Kenya to the Sustainable Development Goals (SDGs), reinstatement of the 2012 guidelines will be inevitable. The abortion law requires review to provide clarity and to avoid conflict between the constitution and the penal code as illustrated by reviewed literature and the interviewed HCPs.

There are permissible conditions under which abortion is legalized in Kenya under the 2010 constitution: to save the life of the woman as well as to preserve physical and mental health. This means that there are legal provisions in Kenyan law under which safe and legal abortion can be provided without contravening the law. Majority of the HCPs are cognizant of the fact that SAC is legal but restricted in Kenya. According to the Kenya Health Bill of 2015, “health” refers to a state of complete physical, mental and social well-being and not
merely the absence of disease or infirmity. Many HCPs argue that this description of health gives provisions to medical practitioners to perform SAC to clients under considerations as broad as social health based on different interpretations. There are however some HCPs who believe that abortion is illegal and is against their personal, cultural and religious beliefs. A HCP reached in the course of this research indicated that he cannot perform an abortion since it is against his conscience. He however indicated that he does refer cases to other HCPs for SAC. This shows there is need to sensitize HCPs against judging patients who seek abortion services. It is also important to strengthen referral structures. Contrary to Kenyan constitution 2010, the penal code Caps. 158, 159 and 160 criminalize provision of abortion services by HCPs and suppliers of drugs and materials used to procure abortion. According to the various stakeholders interviewed, these sections of the penal code should be decriminalized to preserve the gains made by the Kenyan constitution towards the attainment of women’s rights in Kenya. This lack of clarity on the actual legal position of abortion in Kenya is confusing not only to providers of SRHR but also to the legal fraternity.

Post abortion care (PAC) for unsafe abortion complications was provided by both public and private health facilities. The findings of this baseline report showed variations with regard to provision of abortion services between private and public health facilities. Many abortion service providers are in private health facilities while the public health facilities mainly providing PAC hence limiting access and increasing cost of safe abortion services. There is need for training and advocacy among HCPs in the public health sector on abortion service provision to bridge this gap.

5.6 Reviewed best practices policy and legal frameworks for safe and legal abortion

5.6.1 Selected country case studies synthesis

All countries are bound to meet the human rights enshrined in various treaties including the international, regional and respective constitutions at the national level. Together, all these requirements exist as a form of human rights accountability reference system. Essentially, they outline all the aspects a country should satisfy in respect to the protection as well as the fulfilment of human rights.

The issue of abortion has drawn a lot of interest from UN bodies that monitor treaties because of the rising cases of unsafe abortions aggravated by restrictive laws in various regions across the globe. Through its guidelines, Safe abortion: Technical and Policy Guidance for Health Systems, WHO provides a threshold that portrays a classic representation of countries and their varying efforts to satisfy women’s right to comprehensive sexual and reproductive health services. Based on this argument, WHO indicates that laws that respect, fulfill and protect the right to life, non-discrimination on any grounds, right to highest possible health standards, right to information, confidentiality, privacy, right not to undergo degrading and inhuman treatment and education as the good ones. Going by this principle, in the case of abortion, there are basic minimum components achieved by a country that satisfies this definition. By far countries with permissive laws and frameworks supporting all the components or grounds for an abortion have made significant strides in the provision of comprehensive sexual and reproductive health services for women including their right to information regarding safe abortion services.

45https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31794-4/fulltext
Although legalizing abortion in itself may not be the single bullet to reduce the incidences of unsafe abortions, it reduces women’s resort to unsafe abortions and delays in seeking care, and increases service provider willingness to provide care. Countries with friendly abortion policy and legal contexts like Ghana, Ethiopia and South Africa have witnessed a reduction in abortion related mortality and morbidity in the recent years. Whether or not abortion is legalized, women will use any available means to carry out abortion, however unsafe these means are and therefore, it is critical for countries to ensure delivery of quality abortion care services at all levels to prevent severe morbidity and the associated mortality.

Various researchers in their review of global, regional, and sub-regional classification of abortions by safety, distributed abortion safety by the legal status of abortion in a particular country and noted that 87.4% of all abortions in the 57 countries in which abortion was available on request were safe compared with 25.2% in the 62 countries where abortion was completely banned or allowed only to save the woman’s life or to preserve her physical health (Figure 4). This means that the more restrictive the laws on abortion, the less safe the abortions and the higher the maternal morbidity and mortality rate.

The WHO guidance policy on “Safe Abortion Care: the Public Health and Human Rights Rationale” indicated that in countries where legislation is not as restrictive and allows for abortion under some broad indications, there is reported lower incidence of complications from unsafe abortion than in areas where abortion is legally more restricted.

In Malawi, unsafe abortions are very rampant due to the inaccessibility of safe abortion as a result of highly restrictive abortion laws. According to the Penal Code 149 through to 152, abortion is a felony which carries a maximum prison sentence of up to fourteen years. The abortion policy for Malawi is aimed at saving the life of pregnant mothers. It is not available on request, grounds of rape or incest, fetal impairment, economic or social reasons, and preservation of mental health.

Ethiopia expanded its abortion laws in 2005, allowing for abortion in cases of rape, incest or fetal impairment, physical or mental disabilities, as well as if the life and physical health of the pregnant woman is in danger or if she is a minor who is physically or mentally unprepared for childbirth. These changes in abortion laws, combined with the government led concerted efforts to increase access to safe abortions led to the increase in the number of facilities that provided safe abortion services to approximately 4,033.

Sexual and reproductive health rights in Mozambique are recognised in the Mozambican Constitution, and in many legal and programmatic documents. Some of the rights highlighted by these documents include right of all Mozambicans to health services including sexual and reproductive health, equal treatment and access to health services, no discrimination of any kind, the right to choose when and how many children to have, and the right to information, education and access to reproductive health services, particularly for adolescents and youth. In the country, attention has been directed towards mother and child health, including making
family planning services free. Recently in 2014, the nation revisited her laws by relaxing the illegality of abortion to include exemptions for abortion under certain grounds within the first 24 weeks of pregnancy.

Although abortion is legal in South Africa, in 2013, over half of abortions remained unsafe as a result of negative attitudes, high associated costs, stigma surrounding abortion services and lack of awareness of abortion laws and services. The study by Moesley et al., also shows that there are other factors that are associated with unsafe abortions including the factor of moral acceptability of abortion. This shows that there are socio-cultural and moral norms that may impact the success of legal and policy frameworks. This underscores the fact that permissive laws and policy frameworks alone are not the sole solution to unsafe abortion and that engaging communities to have a higher moral acceptability remains a challenge that needs to be addressed.

Countries in group 2 allowed abortion on socio-economic grounds or for mental health reasons.

Countries in group 3 allowed abortion on request. Bars and dots show the point estimates of the proportion of abortions in each category and horizontal lines are 90% uncertainty intervals.

Figure 7 Distribution of abortion safety categories grouped by legal status (adapted from Ganatra et al., 2017)

Countries in group 1 did not allow abortion or only allowed it to save a woman’s life or for physical health.

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Study of countries that have made significant steps in the reduction of maternal morbidity and mortality rates related to unsafe abortion has shown that having the right standards and guidelines is a best practice. Specific case studies of countries such as the U.S and China reveal that these nations have significantly eliminated the high number of back-alley abortion clinics. Even in countries where the law is still somewhat restrictive such as Ethiopia, the presence of the 'Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia’ has had a significant impact on the rates of unsafe abortions in the country.
5.6.2 Selected Kenyan Counties Synthesis: Reviewed Legal and Policy Frameworks

In comparison to many other nations, Kenya still lags behind because it is lacking on legal provisions that explicitly allows procurement of abortion in case of incest, rape, foetal impairment, social economic grounds or even on demand. In fact, the withdrawal of Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion in Kenya in 2013 has complicated interpretation of legality of abortion in the country.

The Kenyan constitution of 2014 provides for induced abortion when the life and health of the mother are at risk, on condition that abortion can only be carried out upon determination by a health care provider. The Kenya Reproductive Health Bill of 2014 provides for abortion or termination of pregnancy upon confirmation by a trained health professional that:

- a) The continued pregnancy would endanger the health of the mother or
- b) As a result of the pregnancy, the life and health of the mother are at risk.

Interestingly, this bill provides for "non-mandatory, non-directed pre and post-abortion counselling" by the health professional, which may be interpreted to mean that the professional can elect whether or not to carry out the counseling. The bill further provides termination of pregnancy for minors and mentally unstable persons with the consent of guardians and parents. The bill does not provide for termination of pregnancy in case of rape or incest or on request. It does not also adequately address the issue of access to abortion services. Figure 9 below demonstrates a summary of permissiveness of abortion laws on reduction of unsafe abortion within selected Kenyan counties.

<table>
<thead>
<tr>
<th>Country</th>
<th>Save the life of the woman</th>
<th>Preserve physical and Mental health</th>
<th>Rape</th>
<th>Incest</th>
<th>Fetal impairment</th>
<th>Socio-economic</th>
<th>On demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya (national)</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Makueni</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Kilifi</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Kakamega</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Figure 9 Review and summary of maternal, neonatal and child health bills in selected Kenyan Counties

Key

✓ Permitted  x Restricted

Although the various counties in the country operate under the same Kenyan constitution, with the devolvement of the health docket, respective counties have come up with their county-based health related bill. A review of some of these shows that there are variations across the counties both from a legal and policy perspective. Provisions regulating termination of pregnancy is one of the areas that has drawn great interest across the nation. For instance, in Makueni, the Maternal New-born and Child Health Bill of 2017 section 6 (1) provides that a pregnancy can be terminated on several grounds recommended by a trained and certified health practitioner and after consulting with the pregnant woman. These conditions include:
• There is a likelihood of physical injury, death or mental health complications on the woman arising from the pregnancy.

• The woman is mentally challenged.

• There is a substantiated risk of mental or even physical fetal deformities.

• The pregnancy is as a result of incest, rape, defilement or sexual assault.

The bill also provides other grounds such as only approved facilities by Medical Practitioners and Dentist Board can offer pregnancy termination services, pregnant woman’s consent and if a minor or a mentally challenged person, consultation with parents or caregivers. While Makueni Bill seems to be making strides to interpret the constitutional provision, the Kilifi Maternal, New-born and Child Health Act of 2016 has raised contention. Section 7 of the bill states that a pregnancy can only be terminated in the event where a health care provider declares need for emergency treatment after consultation with the pregnant women and in an approved facility. The situation is silent for Kakamega’s county Maternal Child Health and Family Planning Act of 2017 that ignores coming up with any guidelines on termination of pregnancy.
Evidence shows that the problem of unsafe abortion in Kenya remains to be a public health concern. If Kenya is to reach its target of reducing maternal morbidity and mortality rate for the achievement of universal health care as well as SDGs, access to SRHR is paramount for adolescent girls and young women. The emerging facts is that the absence of supportive legal and policy frameworks has indirectly led to the proliferation of back-alley establishments and quack medical providers offering abortion related services.

Evidence has shown that having relaxed regulations towards access and conducting safe abortion does not necessarily increase the rates of abortion. Instead, it has been shown that it works towards converting unsafe abortion to safe abortion while the total levels of abortion remain the same. This drastically reduces levels of complications related to unsafe abortion and the burden placed on the health systems to treat those complications. On the other hand, restrictive laws and policies have been shown to increase both the social and financial costs of illegal abortions in the country. At the end of the day, management of complications arising from unsafe abortion costs families and the government much more than it would cost to provide and access safe abortion services.

Many stakeholders reiterated that the country needs an enabling SRHR policy and regulatory environment to enable women and girls seeking abortion services get them conducted in a safe manner. However, there was agreement among many stakeholders that this should be coupled with very strong strategies to prevent unwanted pregnancies.

### 6.1 Strategic advocacy approaches

For the problem of unsafe abortion to be tackled, it is crucial to form strong integrated networks of SRHR stakeholders to forge forward the agenda of maintaining the health and human rights of girls and women. The primary strategy used to advance this mission is consultations with other policy influencers such as the Ministry of Health and direct campaigns through policy formulators with an interest in the state of maternal health – the parliamentarians. A key component of successful advocacy is research that enables advocating entities to present compelling facts about the impact of unsafe abortion and the kind of changes that legalizing abortion would bring. The stakeholders, both in the human rights and SRHR, emphasized the urgency with which policy and legal changes are needed if the deplorable state of maternal health is to improve. Being the players with a direct contact with the situation on the ground, most of the Participants in this study corroborate the secondary data that policy changes are critical if the maternal mortality and morbidity arising from unsafe abortions are to be addressed effectively.

### 6.2 Creation of Awareness about legal, policy frameworks and abortion services at all levels in the community

This study highlighted lack of information, misinformation or inaccurate information especially at the community level about legal and policy frameworks as well as abortion services, impedes the safe abortion agenda. There are many myths regarding safe abortion provision at all levels of the society that lead to negative perceptions and
failure to uptake abortion services. As a result, there is need for targeted awareness campaigns on SAC and PAC at the community level targeting all cadres of people, religions and professionals. It has been shown that some HCPs, who are mandated by law to provide SAC services to women have negative attitudes resulting from misinformation. Law makers need to receive the right information concerning SAC and PAC services in Kenya as well as statistics on mortality and morbidity resulting from unsafe abortions to enable them legislate better abortion laws. Churches, religious organizations and pro-life movements- the greatest opponents of the safe abortion agenda should be approached with humanized stories and statistics on the current status of unsafe abortions to push them to support the agenda. Awareness creation will also help reduce the stigma associated with procuring and provision of abortion services.

6.3 Addressing policy and legal barriers through strengthening policy frameworks

In Kenya, any move taken to introduce necessary policies and legal frameworks that can effectively protect women’s reproductive health is normally met with dedicated resistance from various quarters. Ratification of the Maputo Protocol in 2010 by Kenya marks one of the various achievements in satisfying the call for meeting the health and reproductive rights of women. It ushered in a new era supporting the commitments for respecting and promoting appropriate measures for permitting medical abortion on grounds of rape, sexual assault or even incest among others. Despite this, efforts to push for implementation of protocols codified in law are still needed.

Leveraging on some of the previous efforts of other human rights organizations could spearhead the agenda of strengthening policy frameworks. For instance, in 2016, the National Gender and Equality Commission (NGEC) drafted health standards focusing on women health rights. On the same note, in 2017, the senate debated on the reproductive health bill with various suggested amendments. Kenya Obstetrical and Gynaecological Society (KOGS) and allied members including Federation of Women Lawyers (FIDA) Kenya have been propelling advocacy for the provision of correct information to various stakeholders for more than a decade. Their efforts continue to show fruition considering the gradually changing trends especially in liberal legislation regarding abortion in Kenya today. However, having prevented the total abortion ban is not enough since restrictions that favor unsafe abortions still exist. As a result, these organizations remain adamant in championing for policy changes and formulation of guidelines towards this goal.

6.4 Addressing unsafe abortion through health standards and guidelines

By the time Kenya was adopting the 2010 constitution, there were serious limitations in availability of guidelines for implementing the changes brought about by both Article 26 (4) of the Kenyan constitution and Article 14 (2) c of Maputo Protocol. In fact, the Post-Abortion Care Trainer’s Manual by the government was the only existing guideline by then. As a result, healthcare providers and patients seeking the services remained in a dilemma in determining what circumstances proved legality of abortion. The case was even more uncertain because this existing governmental guideline was largely contradictory as well as confusing. One of this scenario is where it indicates that any induced abortion in Kenya is illegal while at the same time arguing that the law allows abortion for the preservation of the life of a woman. The uncertain conditions were aired by IPAS Kenya in 2011, and by 2012, some changes emerged in the codes of ethics and codes of practice revisions for the nurses, medical practitioners and clinical officers allowing them to offer abortion services during certain circumstances. To prevent the rising number of women charged with procuring abortion, averaging 3 cases a week as reported by Centre for Reproductive Rights Kenya, the Ministry of health commissioned pro-abortion NGOs to draft guidelines.
In 2012, the Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortions inclusive of the WHO’s 2012 Safe Abortion Guidelines were published. This provided a roadmap for improving safe abortion in the country in line with the constitution. The principle of the guideline was that pregnancy termination remained lawful as long as it was facilitated by a trained and skilled medic as provided for by the law. Later on, there was a nationwide training of nurses and other mid-level care providers based on the curriculum provided by the ministry of health. Unfortunately, restrictions imposed on USAID funding supporting a significant proportion of Family Planning Provision in Kenya saw the Ministry of Health suddenly withdraw the guidelines and standards in 2013, and this brought to an end the achieved safe abortion milestones in the public healthcare facilities. Consequently, this has restored the confusing status quo where stakeholders remain unsure of what is and what is not permissible legally due to the lack of guidelines. As a result, as many abortion providers close their services, backstreet ones offering unsafe abortion have been on the rise since 2014.

From the baseline survey findings, the following summary of recommendations should be considered to ensure success of the upcoming programme:

- There is need for the government to have policies that will support the tackling of unsafe abortions. The discourse currently attracting a lot of attention is that the lack of guidelines, together with an unsupportive law has a tremendous influence on increasing abortion-related maternal mortality and morbidity rates. Successful advocacy for the reinstatement of the withdrawn standards and guidelines will provide an opportunity for building capacity of HCPs to identify special cases that may require safe abortion intervention, in light of the various characteristics that influence the decisions for safe abortion gestational age, physical, mental and social health and well-being of the woman/girl. This will also increase the capacity of HCPs in conducting safe and legal abortions averting cases of unsafe abortions nationally. It was recommended that the reinstatement of the standard guidelines for health care providers to prevent and manage abortion complications in order to reduce maternal mortality and morbidity.

- There is need for the government to have budgetary allocation on family planning, and on awareness creation among the reproductive age group.

- The government to have in place policy and guidelines on the right to contraceptives among reproductive age groups.

- There is need for enhanced education on sexual and reproductive health issues in the community and especially those associated with prevention of unsafe abortion practices.

- Strongly advocate for the amendment of the penal code and the 2010 Kenyan constitution to ensure harmonization and more clarity on abortion provisions to avoid confusion and divergent interpretation. In specific, FIDA-Kenya should work towards the amendment of Sections 158, 159 and 160 of the penal code that hinder smooth provision of SAC and PAC services.

- Work closely with SRHR stakeholders, religious and community opinion leaders in order to develop mutually agreeable ways of breaking the silence surrounding the adverse effects caused by high rates of unsafe abortion. Working directly with such important players can help them appreciate the negative effects of unsafe abortion and turn them into important advocates of a lasting solution. Establish strategic partnerships with relevant organizations that share similar agenda. This will create synergy through responsibility and knowledge sharing.
APPENDIX I: THE WORK PLAN

The end term evaluation will take a total of 30 days as outlined in the schedule below. A detailed work plan will be produced as part of the inception report upon consultation with the FIDA Kenya team.

### Work Schedule for a Baseline Survey of the Project “Safeguarding Constitutional Rights to Safe and Legal Abortion for Girls and Women in Kenya”

<table>
<thead>
<tr>
<th>TIME PERIOD-</th>
<th>ACTIVITIES</th>
</tr>
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<tbody>
<tr>
<td>18TH OCT. TO 16TH NOV. 2018</td>
<td><strong>Preparatory / Inception</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Meeting with FIDA KENYA team</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Signing of contract</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mobilization training of research assistant’s</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Piloting of tools</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Refinement of tools</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Desk review of legal and policy aspects of safe abortion and identifying safe practices</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Conduct a mapping of SRHR Stakeholders in Kenya</strong></td>
</tr>
</tbody>
</table>
### Field visits

- Nairobi: KII, FGDs, In-depth interviews
- Kisumu: KII, FGDs, In-depth interviews
- Nakuru: KII, FGDs, In-depth interviews
- Mombasa: KII, FGDs, In-depth interviews

### Data Handling and Report Writing

- Preparation of field reports
- Transcription of qualitative data
- Data Analysis and interpretation
- Preparation Zero draft report
- Incorporate comments from FIDA Kenya.
- Prepare final report

### APPENDIX II: THE FINANCIAL PROPOSAL

Our proposed professional fees and other consultancy costs will be KES 658,000 based on an estimated time input in person days of 30 calendar days. The proposed payment plan is that 30% be paid before the start of the assignment and the balance at the end of the assignment.
<table>
<thead>
<tr>
<th>EXPENSE CATEGORIES</th>
<th>BASELINE SURVEY COSTS</th>
<th>TOTAL AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unit of Measurement</td>
<td>No. of units</td>
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<tr>
<td>1. Staff Cost (Staff cader)</td>
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</tr>
<tr>
<td>Supervisor</td>
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<tr>
<td>Research assistants (Data collection for FGDs/KIIs)</td>
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<td>10</td>
</tr>
<tr>
<td>Statistician</td>
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<td>4</td>
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<td><strong>Subtotal Staff Cost</strong></td>
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<td></td>
</tr>
<tr>
<td>2. Survey Activities</td>
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<tr>
<td>Finalizing research strategy prior to initiation</td>
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<td>1</td>
</tr>
<tr>
<td>Development of data collection instruments</td>
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<td>1</td>
</tr>
<tr>
<td>Collection and review of documents</td>
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<td>3</td>
</tr>
<tr>
<td>Development of data entry screen/matrix</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Transcribing/Data entry</td>
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<td>4</td>
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<tr>
<td>Analysis of desk reviewed data</td>
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<td>2</td>
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<tr>
<td>Field data analysis</td>
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<td>6</td>
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<tr>
<td>Report writing</td>
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<tr>
<td><strong>Subtotal</strong></td>
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<td>3. Transport and Accomodation</td>
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<tr>
<td>SGR train fare to Mombasa</td>
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<tr>
<td>Air Fare to Kisumu</td>
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<td>Transport to and within Nakuru (car hire)</td>
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<td>Accommodation (Outside Nairobi)</td>
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<tr>
<td>Transport within Kisumu and Mombasa</td>
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<td>10</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Other Survey Related Expenses</td>
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<td></td>
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<tr>
<td>FGD and In Depth Interviews transport reimbursement</td>
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<td>4</td>
</tr>
<tr>
<td>Airtime and internet</td>
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<td>3</td>
</tr>
</tbody>
</table>
APPENDIX III: Informed consent letter

This is a baseline survey to have a complete understanding of the situation of safe versus unsafe abortion in Kenya as well as identifying the policy and legal gaps in regards to safe abortion for the project “Safeguarding Constitutional Rights to Safe and Legal Rights for Girls and Women in Kenya”, a five year project FIDA is planning to start. We therefore would like you to voluntarily provide us with any information you may have regarding the subject of abortion. We will guide you with questions that you may choose to respond to or not.

How long will the focus group discussion last?:-
This will take approximately 30 minutes to 1 hour to complete. We may contact you again if we need further clarifications from you on your responses or certain follow up questions from you.

What are the risks of the study?:-
The time and effort you take to be a participant. You may find one or more questions that we ask to be upsetting or emotionally sensitive. You do not have to respond to any question that makes you uncomfortable. You may end the interview at any time without penalty or loss of any benefits to which you are entitled. A risk may be a breach of confidentiality (something you say is accidentally provided to others) but we will take precautions to see that this does not happen. We would like to assure you that your responses will be kept in the strictest confidentiality and your name will not be linked to audio recordings, transcripts and our notes.

What are the benefits of participating? – There are no direct benefits to you for participating in the study.
You may find an indirect benefit in knowing you have participated in an important study that could help others in the future. However your transport will be reimbursed to the tune of KES 300 at the end of the discussion.

Confidentiality:- Will my participation in the study be kept confidential? During the study, personally identifying information and study information that is collected will be kept confidential. No one will be told that you have participated in the study. Your name or other identifiers will not be included in reports or transcripts from this study. This data will be stored on a password protected computer and the hard copies e.g. questionnaires will be safely locked up with only the study team able to access them.

I have been sufficiently informed about the procedures for this research, benefits and risks and I choose to participate;

Date ____________________________
Name and signature or mark of participant ____________________________
I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Date ________________________________

Name and signature of person who obtained consent

______________________________

APPENDIX IV: Guiding questions for key informants, focus group discussions

Key Informant Interview Guiding Questions

1. Are you a provider of abortion services?  
   Probe: What type of services do you provide?  
   (Example: Provision of education, information, provision of abortion services, provision of psychosocial support etc)

2. What is the coverage of your services?
   a. National?
   b. Regional (Western, Eastern, Central, North Easter)
   c. County?

3. Do you know any stakeholders or institutions in your area, other than your institution that support and advocate for safe and legal abortion? Probes: What are the names of these stakeholders or institutions? What services do they provide? What is their geographic area of coverage?

4. Are you aware of any young girls or women in your area of jurisdiction that have either secured an abortion or sought abortion services? Probes: How many girls or women known to you have ever procured an abortion or sought abortion services? How many of these girls and women have benefitted from your services? What age cohorts are your clients?

5. Can you name other providers of abortion services known to you? What type of services do they provide? Do they have a national, regional or county coverage?

6. Do you know the reason(s) as to why young girls and women choose to or not go for abortion?

7. What are some of the health care provider’s attitudes towards pre-abortion and post abortion care? Do these attitudes affect accessibility to abortion services?

8. Are male spouses or partners involved in the process of seeking for abortion services?  
   Probe: What is the nature, level, extend and degree of their involvement?

9. What are the constitutional, legal and/or policy frameworks governing abortion services in Kenya?

10. Are you aware of any other factors (not mentioned above) such as living with HIV/AIDS, sexual orientation, marital status, among others that may influence decision making for or against abortion? What are these factors?

11. What are some of the challenges you go through as a stakeholder in safe and legal abortion service delivery?

12. What are the perceptions, attitudes and views of your church towards abortion and abortion services in your local area and in Kenya?

13. Are there any form of stigma that may deter abortion service accessibility in your area of jurisdiction and in Kenya?

14. Is there any form of misinformation or lack of accurate information that may deter abortion service accessibility in your area of jurisdiction and in Kenya?

15. Are there gestational limits that may deter abortion service accessibility in your area of jurisdiction and in Kenya?
16. Are there infrastructural or logistical characteristics that may deter abortion service accessibility in your area of jurisdiction and in Kenya?

17. Does religion or culture in your area of jurisdiction limit access to health care specifically abortion services?

18. What role do male spouses or partners play for women seeking abortion services?

19. Are abortion services readily available in your locality? How many service providers known to you provide abortion services?

20. What conditions would lead to a woman's failure to access abortion services upon visiting an abortion service providing centre?

21. What is the cost of abortion services in your area? Probe: Is this affordable to your clients? Would a lowered cost of abortion services encourage girls and women to procure an abortion?

22. How do health care providers perceive women seeking for abortion services? Are there cases that have been reported to you where health care providers had a negative attitude towards women seeking abortion services?

23. Are there any legal and policy barriers/issues that would deter you providing abortion services? Are there any legal and policy barriers policy/issues that have been reported by your clients?

24. Does the autonomy, religious or personal convictions of doctors against performing an abortion affect the accessibility of abortion services?

**Focus Group Discussion Guiding Questions**

1. Are you aware of any young girls or women that have either procured an abortion or sought abortion services? Probe: How many girls or women known to you have ever procured an abortion or sought abortion services?

2. Of those known to you to have sought abortion services or carried out an abortion, how many are young girls? How many are women? Probe: What age cohorts are affected in (iii) above? (Age bracket)

3. Can you name any providers of abortion services known to you? Probe: What type of service do they provide?

4. Do you know the reason(s) as to why young girls choose to or not go for abortion?

5. What are some of the health care provider’s attitudes towards pre-abortion and post abortion care? Probe: What do you think is the reaction of a health care provider when a young girl or woman seeks abortion services?

6. Has any of you ever been involved in the process of seeking abortion services for your partner/spouse? Probe: What is the level, extend and degree of your involvement?

7. Are you aware of any constitutional, legal and/or policy provisions regarding abortion services? Probe: What are the exact provisions?

8. Are you aware of any other factors (not mentioned above) such as living with HIV/AIDS, sexual orientation, marital status, among others that may influence a woman to or not carry out abortion? Probe: What are these factors?

9. What do you know about safe and legal abortion and abortion services your local area and in Kenya?

10. What are your personal perceptions, attitudes and views towards abortion and abortion services in your local area and in Kenya? Probe: Do you support safe and legal abortion?

11. Does your community (family, friends, colleagues and the larger society) know about safe and legal abortion and abortion services in your local area and in Kenya? Probe: Does your community support safe and legal abortion?
12. Is there any form of stigma, misinformation or lack of accurate information, gestational limits, infrastructural or logistical characteristics that may deter service accessibility? **Probe:** What is the cause of this stigma?

13. Do you know of any person(s) who has ever experienced any form of stigma, misinformation or lack of accurate information, gestational limits, infrastructural or logistical characteristics that may deter service accessibility?

14. Does your religion or culture limit access to safe and legal abortion services? **Probe:** What religious or cultural norms limit access to safe and legal abortion services?

15. What role do you play, as a male partner or spouse for your partner(s) or women seeking abortion services?

16. Are abortion services readily accessible in your area? **Probes:** How many service providers known to you provide abortion services? What is the average distance to the nearest abortion service provider?

17. What conditions would lead a girl or woman to fail to access abortion services upon visiting an abortion service providing centre? **Probe:** Do you know of any girl or woman who has had an abortion or wanted to?

18. What is the cost of abortion services in your area? **Probes:** Is this affordable to many young girls and women seeking safe and legal abortion services? Would a lowered cost of abortion services encourage you to procure an abortion?

19. How do health care providers perceive women seeking for abortion services? **Probes:** Are you aware of any young girl or woman who has received improper treatment while seeking safe and legal abortions services? What was the cause of this improper treatment?

20. Are you aware of any legal and policy barriers policy issues known to you that would deter young girls and women from seeking and accessing safe and legal abortion services?

**Religious Leaders’ Interview Tool**

1. What are your personal perceptions, attitudes and views as a religious leader towards abortion and abortion services in your local area and in Kenya? Do you support safe and legal abortion for young girls and women?

2. Are you aware of any young girls or women in your congregation that have either secured an abortion or sought abortion services? **Probe:** How many girls or women known to you have ever procured an abortion or sought abortion services? (Number)

3. Are you aware of any constitutional, legal and/or policy frameworks regarding abortion services? Do you as a religious leader or as a church support these frameworks?

4. What are the perceptions, attitudes and views of your church towards abortion and abortion services in your local area and in Kenya?

5. What are your personal perceptions, attitudes and views as a religious leader towards abortion and abortion services in your local area and in Kenya? Do you support safe and legal abortion for young girls and women?

6. Does the autonomy, religious or personal conviction of doctors against performing an abortion affect the accessibility of abortion services?
In-depth Interviews with Health Service Providers

1. **What is your experience with abortion care?**
   **PROBE FOR:**
   - how many abortions cases do you encounter in a day/week
   - Why do clients come to you, straight for the services or after complications
   - How do you make decision to offer abortion services
   - What reason do women or/and girls give for aborting
   - What complications do you encounter while offering abortion services
   - What are the main reasons girls/women seek to abort
   - Who is aborting babies?
   - Legality of abortion
   - How costly are abortion services
   - How do clients know about your abortion services

2. **Where do women/girls seek abortion services PROBE FOR:**
   - Public health facilities
   - Private health facilities
   - Mission health facilities
   - Private clinics disguising as other services
   - Pharmacy
   - Undesignated health facilities
   - How did you find the services
   - Back street clinics

3. **What considerations would you consider when deciding to offer abortion services**
   **PROBE FOR:**
   - duration of pregnancy
   - Whether the client has money
   - Physical health of woman/girl
   - Psychological health of woman/girl
   - Any underlying complications
   - Post abortion care and psychological support including family planning
   - Role of partner etc
   - Urgency
   - Pre abortion care and psychological support

4. **How would you want abortion services in Kenya to be like? PROBE FOR**
   - Legalized and be offered in all health facilities
   - Advertised like other services
   - To be offered like other reproductive health services
   - To be without stigmatization
   - Health care providers to be trained to offers services
   - To be free or catered for by NHIF
   - Review the law and policy to legalize abortion
   - Any other

5. **Do you have any other comments to add to this discussion?**