

# Lived experiences and pathways to abortion in Kilifi County, Kenya

Evidence brief

## Introduction

According to the Kenya Demographic and Health Survey of 2014, over 35% of pregnancies reported in Kenya were unintended. Nearly half of these pregnancies end in induced abortions with a substantial proportion resulting in mild to severe complications, long-term disability and death. While there is increasing research on the context of abortion in Kenya, few studies have explored how access to information, socio-cultural and economic factors, sexual and gender-based violence (SGBV) and the different actors involved, drive unintended pregnancies and influence the abortion decision-making process, abortion methods and the management of abortion-related complications. Further, most research on abortion has disproportionately been focused on urban areas with very little information available on how abortion is navigated in rural areas.

APHRC, Rutgers and Kilifi County Department of Health carried out a six-month ethnographic study in two sub-counties within Kilifi county covering both rural and urban settings. We conducted participant observations in four public health facilities and surrounding communities. Thanks to the immersion in the facility and the community, as well as a snowball sampling approach, we identified 54 girls and young women (14-30 years of age) who were followed up throughout the study period. We conducted informal conversations and repeated in-depth interviews with the girls and young women, as well as their partners and relatives (including mothers, sisters, grandmothers, aunts, friends). Furthermore, 12 focus group discussions were also conducted with youth aged 15-24, and fathers and mothers of adolescents in the community, in addition to 31 key informant interviews (community leaders, pharmacists, Post - Abortion Care (PAC) providers and policymakers).

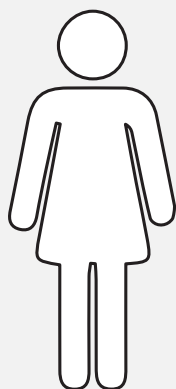


## Findings

### i. Factors contributing to unintended pregnancies

- Findings indicate that family and individual-level factors interplay to increase the exposure of girls and young women to risky sexual behavior, in particular, socioeconomic factors enhanced their vulnerabilities. Many girls and young women lived in abject poverty and lacked parental support which was then associated with school dropout and unemployment. This further increased the likelihood of girls engaging in transactional sex, intergenerational sexual relationships, or dating *boda boda* riders to meet their financial needs.





“ I was in a relationship not by will but because I needed the money he gave me and I was influenced by my friends to be in it. He would give me money that I would use to buy myself things. At first the relationship was good and he treated me well, he took me to nice hotels.  
18 year-old Shop Attendant. ”

- Findings show that the nature of the sexual relation participants were engaged in varied widely for the 54 girls and young women; 31 of 54 were dating boys/men of similar age, 10 were dating married men, 1 was in a casual relationship, 4 were raped or defiled, 4 were sex workers in relationship with former clients and 4 did not disclose any details (Figure 1). In nearly all instances, girls and young women (especially those who were unmarried) reported they were pressurized by their partners to engage in sexual intercourse, with one citing she was sexually abused by her father who later forced her to terminate the pregnancy.

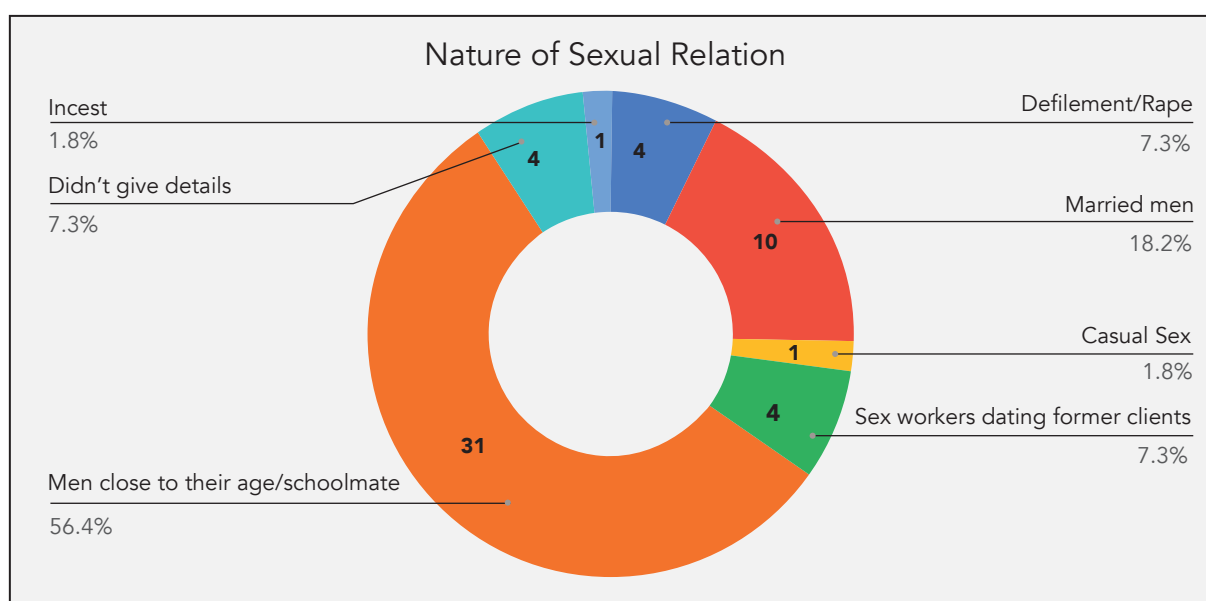


Figure 1: The nature of the sexual relation participants were in when they became pregnant

- Girls and young women reported receiving conflicting information on sexual practices and risk management. Parents were reported to be more keen on abstinence and discouraged girls from the contraceptive-centered sexuality education taught in schools, and promoted by the media and non-governmental organizations. Further, stigma from healthcare providers and the community, as well as fear of side-effects and partner influence led to a low uptake and discontinuation of contraceptives by young people. Together, these factors were found to further put girls' and young women at risk of unintended pregnancies (Figure 2).

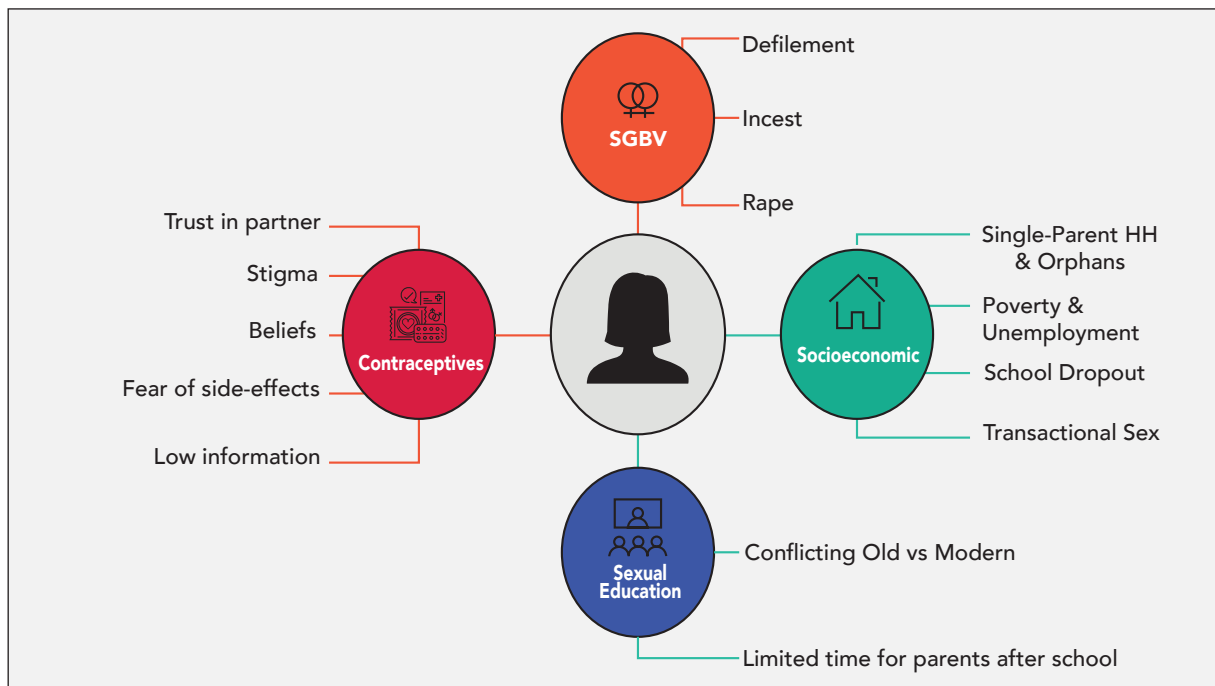
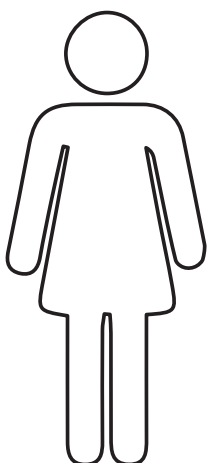


Figure 2: Factors driving unintended pregnancy among participants

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

- Decision-making around abortion proved to be complex, non-linear and driven by various reasons and actors. Girls often faced the dilemma of bearing the consequences of an unintended pregnancy or having an abortion (Figure 3).
- Girls decided to terminate their pregnancy for various reasons including fear of dropping out of school, the lack of resources to cater for themselves and the unborn child, and fear of stigma from the community. Often the decision was based on a cummulation of these factors.
- Male partners were highly influential in decision-making, and girls were at times compelled to abort when their partner denied responsibility for the pregnancy.
- We documented four cases where the pregnant girl or young woman did not have the opportunity to make her own decision to abort, but was rather made to take an abortion drug against her will.



“ I was scared people will find out about the pregnancy, especially my mother. ”

“ The person that I was with gave me medicine without my knowledge. When he found out that I was pregnant he made a plan to force me have an abortion. ”

“ Since he denied the pregnancy, his phone went off, I have never gotten in touch with him again. ”

“ I wasn't willing to leave the chance to join college. ”

### iii. Care / help-seeking pathways to abortion

- In most cases, girls lacked access to information on (safe) abortion methods, since abortion is highly stigmatized and associated with severe complications including death.
- Girls and young women especially those in rural settings, sought information, guidance and financial support from various sources and actors discreetly. The level of secrecy involved influenced the persons from whom they could seek information, the type of information they received, the method used, and the care they received.
- Most girls preferred 'traditional' methods of abortion because of their perceived social safety (in terms of discretion) and ease in accessibility as compared to medical and surgical methods seen as expensive and socially and medically unsafe (Figure 3).
- In most cases, girls mixed 'traditional' methods to ensure it is successful and eventually had to make multiple attempts before succeeding in terminating the pregnancy. This increased the risk of complications and the cost of care.

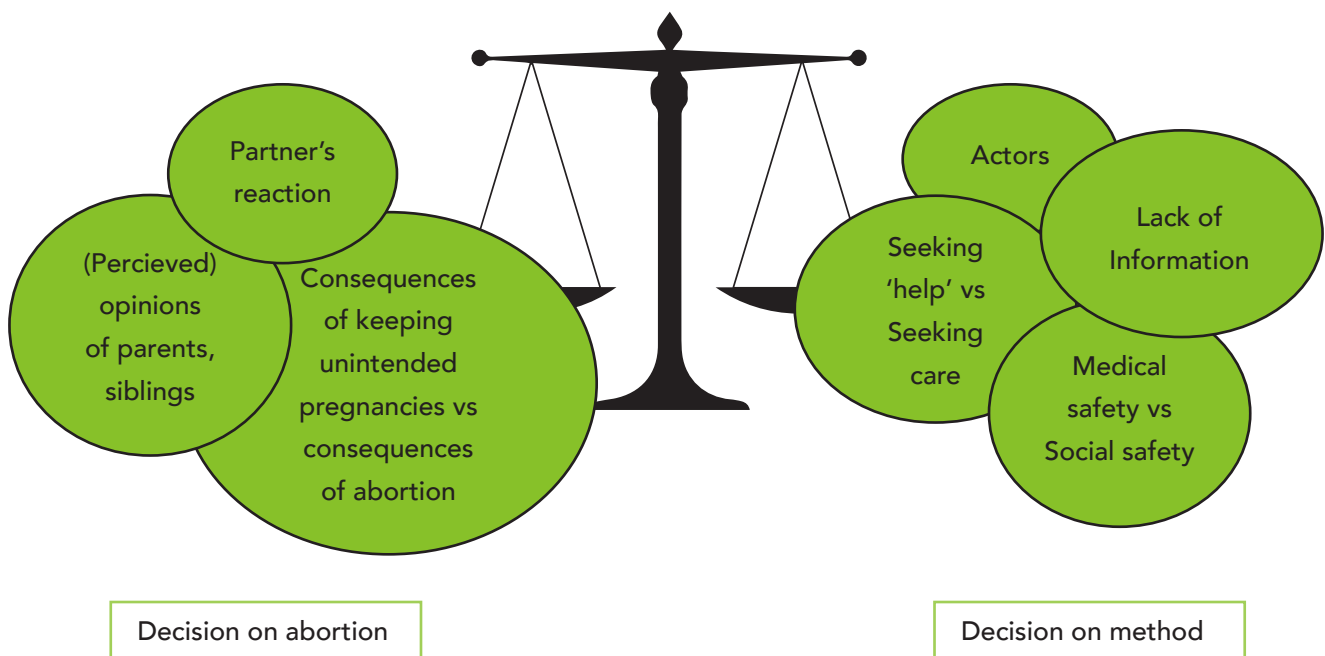
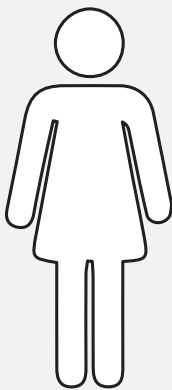


Figure 3: Pathways on the decision to abort and deciding on methods

#### iv. Post abortion care: When things get out of control

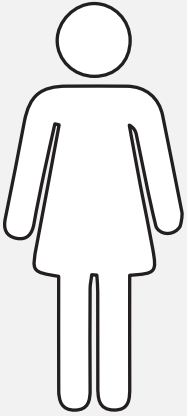


- Girls often experienced post-abortion complications, however, their fear of stigma and interpretations of the complications prevented or delayed them from seeking care.



“ I didn't want to (seek help) because if I went for example to the government hospital, they would have known what the problem was and I didn't want that. I endured the pain praying to God: Let there be nothing else that will happen. (21-year-old, Waitress). ”

- In public health facilities, lack of equipment and trained staff, challenges with diagnosis of abortion, and the systematic prescription of ultrasound scan (to diagnose the abortion) hindered timely access to post-abortion care services.
- In addition, unfriendly responses by providers, long waiting time, lack of privacy and autonomy while accessing PAC services were reported as hindrance to quality of PAC.
- Findings show missed opportunities around PAC contraceptive counselling due to absence of counseling in some cases, women failing to return to the facility for review as requested by the provider, or refusals of girls to use contraceptives due to their partners' influence and the fear of side effects. This led to repeat unintended pregnancies.
- Although the PAC services are expected to be free in public health facilities, most PAC patients had to pay for these services in three of the four facilities involved in the study. We noted that the cost depended on the provider and patients ability to negotiate the price. In cases where the patient could not afford the care, they sought services elsewhere or waited and returned when they had adequate funding.



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

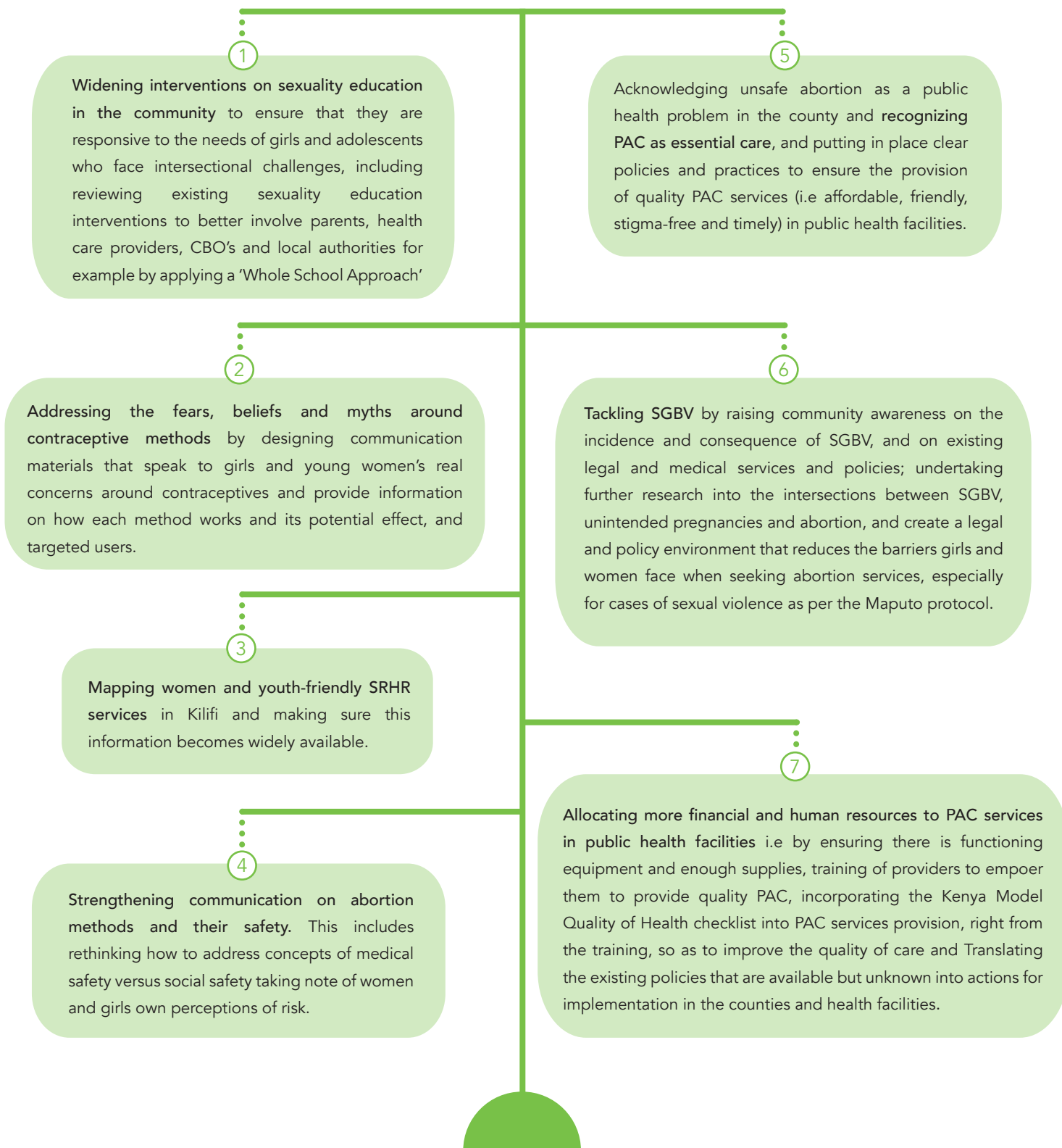
#### v. SGBV and abortion

- The findings showed that SGBV and abortion intersect in multiple ways: SGBV drives unintended pregnancies (through incest, defilement and rape), influences abortion decision making (through forced abortion and coerced decision making) and care seeking pathways (abusive healthworkers) through unequal power dynamics, abuse and coercion.



## Conclusion & Recommendation

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





## Acknowledgement

This research was conducted as part of the She Makes Her Safe Choice Program funded by the Dutch Postcode Lottery from 2018-2021. For more information see: <https://rutgers.international/programmes/she-makes-her-safe-choice/>

## Citation

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



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