

## Conclusions in Brief

### A System in Crisis from Contraception to Post-Abortion Care

#### CONCLUSION ONE: ACCESS TO CONTRACEPTION IS PRECARIOUS FOR BOTH MARRIED AND UNMARRIED WOMEN

##### The context:

- Kenyan women experience high rates of unwanted and unplanned pregnancies and have limited access to contraceptives and family planning information.
- According to the 2003 Kenya Demographic and Health Survey (KDHS), “nearly 20 percent of births in Kenya are unwanted and [an additional] 25 percent are mistimed (wanted later).”<sup>7</sup>
- According to the 2009 KDHS Preliminary Report, the modern contraceptive prevalence rate for married women is 39%.<sup>8</sup> The 2003 KDHS also found that 25% of married women in Kenya have an unmet need for family planning; the unmet need is even higher than 25% for women aged 15–24 and 30–34.<sup>9</sup>

##### Research conclusions:

- **Women encounter multiple barriers to contraceptive access.** Access to contraceptives in Kenya is limited by the government’s failure to ensure an adequate and consistent supply of contraceptives and the effective dissemination of accurate family planning information, financial barriers to contraceptive access, and discriminatory service provision stemming from the stigma surrounding women’s and girls’ sexuality in Kenya.
  - The Kenyan government’s failure to procure sufficient contraceptive stocks has meant that Kenya’s public health facilities have consistently suffered from severe shortages, or “stock-outs,” of contraceptives in recent years.<sup>10</sup>
  - The Kenyan government has failed to effectively disseminate accurate family planning information. According to the 2003 KDHS, 25% of women<sup>11</sup> and 29% of men<sup>12</sup> had not been exposed to family planning messages through the media, including radio, television and newspapers/magazines, in the months preceding the survey.
  - In addition to supply shortages, Kenyans also face financial barriers to obtaining contraceptives. Despite the Ministry of Health’s policy that contraceptives should be available free of charge, the 2004 Kenya Service Provision Assessment Survey (2004 KSPAS) found that 42% of government facilities charged user fees for family planning services and 8% of government facilities charged for the contraceptive method itself.<sup>13</sup> The private sector poses similar financial obstacles to contraceptive access. Although private drug stores do have contraceptives consistently in stock, their prices are often too expensive for most Kenyans.<sup>14</sup>
- **A lack of meaningful access to a comprehensive range of contraceptive methods puts women and girls at a greater risk of unintended pregnancy.**
  - Reported *The Standard*, “[p]oor women who cannot afford contraceptives are turning to uncertified herbal medicines,” which pose life-threatening side effects and are of questionable effectiveness.<sup>15</sup>
  - According to the current Minister of Medical Services Anyang’ Nyong’o, unintended pregnancies from poor access to contraceptives have driven up the rate of illegal abortions.<sup>16</sup>

## CONCLUSION TWO: KENYAN ADOLESCENTS ARE ILL-INFORMED ABOUT SEXUAL HEALTH AND LACK ACCESS TO CONTRACEPTION

### The context:

- Kenya has high rates of teenage pregnancies and Kenyan youth receive limited sexuality education in schools.<sup>17</sup>
- An estimated 5.5 million Kenyan girls between the ages of 15 and 19 give birth annually.
- Youth in Kenya lack basic information about sex and reproductive health. Although the 2003 KDHS found that 52.8% of women aged 20–49 and 57.4% of men aged 20–54 had sex by their 18th birthday,<sup>18</sup> sex education in secondary schools in Kenya is limited<sup>19</sup> and, in some cases, nonexistent.<sup>20</sup>

### Research conclusions:

- **Lack of information and widespread misinformation about sexuality and reproductive health leads to unwanted pregnancies.** With minimal, and sometimes inaccurate, information about contraceptives and family planning at their disposal, many Kenyans—adolescents, in particular—are ill equipped to prevent unwanted pregnancies.
  - Misinformation about sexuality and pregnancy prevention is widespread: one example is a 17-year-old boy from St. Georges Boys Secondary School in Kilifi, who was told that “if one has sex while standing, pregnancy will not occur.”<sup>21</sup>
- **Adolescents are often unaware of available family planning services.** A focus group discussion held by the Center for Reproductive Rights with young women and girls in Mombasa, many of whom believed they could not afford EC, revealed that many did not know that contraception is free in government facilities.<sup>22</sup> Further, focus group participants from Kibera voiced the belief that family planning was exclusively for married women; as one participant stated, “we are not married so family planning is not for us.”<sup>23</sup>

## CONCLUSION THREE: UNWANTED PREGNANCY, DISCRIMINATION AGAINST PREGNANT SCHOOLGIRLS, AND ABORTION STIGMA DRAMATICALLY REDUCE EDUCATIONAL OPPORTUNITIES FOR SCHOOL-AGE GIRLS

### The context:

- Girls in Kenyan schools are exposed to sexual abuse, receive limited sexuality education—particularly about access to safe abortion, and may be forced to drop out or are expelled by the school administration upon becoming pregnant.
- The lack of sexuality education in Kenyan schools, poor access to information about sexual and reproductive health more generally, sexual coercion and violence and limited access to reproductive health services for Kenyan youths has led to high rates of teenage pregnancy in Kenya. According to the 2003 KDHS, 37.7% of girls have begun child-bearing by the age of 18;<sup>24</sup> and 13% of secondary students surveyed nationally had experienced their first pregnancy by age 14.<sup>25</sup>
- A 2009 report by the Teachers Service Commission (TSC) and the Centre for Rights Education and Awareness estimated that 12,660 girls were sexually abused by their teachers in Kenya between 2003 and 2007. These numbers may be underestimates given the report’s finding that “90 percent of sexual abuses cases never reached the TSC.”<sup>26</sup>

- Pregnant girls are often expelled or forced to leave school once teachers and school administrators discover the pregnancy. Despite government policies designed to protect a pregnant girl's right to continue her education, 13,000 girls leave school every year in Kenya due to pregnancy, according to a recent study by the Centre for the Study of Adolescence.<sup>27</sup> As a result, only 35% of Kenyan girls between the ages of 16 and 20 are still in school, while almost half of boys the same age are, despite the similarity of enrollment numbers when the boys and girls were younger.<sup>28</sup>

#### Research conclusions:

- **Pregnant girls cite the stigma of pregnancy and discrimination by teachers and peers as the main reason that they are forced to leave school.**<sup>29</sup> Girls who attempt to return to school after pregnancy face humiliation and isolation—according to a 2008 study, fellow students “do not interact with them freely, partly at the instigation of teachers, who view the returning students as a bad influence.”<sup>30</sup>
- **Teachers and school administrators sometimes refuse to allow girls to return to school after giving birth for fear that “other girls would think that it is okay to get pregnant.”**<sup>31</sup> Since the girls may lack strong support systems, they often are not in a position to challenge mistreatment or expulsion.<sup>32</sup> According to news reports, at the Marinyn Secondary School in James Finlay Tea Estates in Kericho, all but one of twenty-five girls in the 2009 Form One class were forced to drop out of school due to pregnancy,<sup>33</sup> similarly, twenty-eight girls between the ages of 11 and 15 dropped out of a primary school in Kinango District in 2009 after becoming pregnant.<sup>34</sup>
- **Many schoolgirls, unwilling to risk their education because they have become pregnant, terminate their pregnancy in order to continue their education.** According to the 2006 study on Kenyan adolescents' abortion discourse, “[s]econdary school students are more likely to pursue abortion as a strategy than their out-of-school age peers.”<sup>35</sup>
- **In seeking abortion, young women risk—and sometimes lose—their lives.**
  - o The case of a young orphan girl is one such example. In spite of being orphaned, she had scored top marks on her KCPE (Kenya Certificate of Primary Education) exam and her local Minister of Parliament was helping to fundraise for her school fees. When she discovered that she was pregnant and would not be able to continue on her promising educational path, she sought an illegal, unsafe abortion. She bled to death from the procedure.<sup>36</sup>
  - o The consensus during a Center for Reproductive Rights focus group discussion among adolescents and young women in Kibera, a large informal settlement in Nairobi, was that “you cannot go to a public hospital for an abortion.”<sup>37</sup> Instead, the girls agreed that “the most common way to get an abortion is backstreet and when that fails you go to the hospital.”<sup>38</sup>
- **Procuring an abortion can also mean risking one's education, placing pregnant girls in an impossible situation.** In the early months of 2009, Mary, a young girl in secondary school in Mbita, became pregnant. An orphan who lived with her grandmother, Mary realized that being pregnant and having a child would not allow her to continue with her education. She went to a private provider in Mbita to have the abortion and then returned to school. According to her close friend, who was interviewed for this report, “The teachers knew she had been pregnant. She started bleeding in school, behind the classroom. The teacher called her and said to go to home and be pregnant again. If she couldn't do that, she shouldn't come back. Now she's at home and this has made her not finish school. She won't go back to school because she was chased away.”<sup>39</sup>

## CONCLUSION FOUR: SEXUAL VIOLENCE AND “SURVIVAL SEX” IS PREVALENT AND LEADS TO UNWANTED PREGNANCIES AND UNSAFE ABORTION

### The context:

- High rates of sexual violence in Kenya, particularly during the post-election violence in 2008-09, contribute to unwanted pregnancies.
- In a 2003 survey of 1,652 Kenyan women between the ages of 17 and 77, 52% reported being sexually abused in their lifetime while over 30% reported an experience of forced sexual intercourse in their lifetime.<sup>40</sup>
- According to the 2003 Kenya Demographic and Health Survey (2003 KDHS), “[m]arital rape appears to be common, with 15 percent of married women and separated or divorced women reporting having experienced forced sexual intercourse; 12 percent report this experience in the 12 months preceding the survey.”<sup>41</sup>
- A 2008 United States Agency for International Development (USAID) study determined that Kenya has one of the highest rates of sexual violence between intimate partners of the ten countries surveyed, at 15%.<sup>42</sup> The data also indicated a statistically significant relationship between intimate partner violence and unintended pregnancies.<sup>43</sup> According to the same study, in Kenya, a slightly higher percentage of abortions are procured by women who have experienced intimate partner violence than by those who have not.<sup>44</sup>

### Research conclusions:

- **Sexual violence, in the form of rape and gang rape, was a significant component of Kenya’s post-election violence in 2007–08.** The Commission of Inquiry into Post-election Violence dedicated an entire chapter of its final report to sexual violence, documenting testimonial evidence from both survivors and medical professionals relating to the marked increase in sexual offenses during the post-election violence. Witnesses testifying before the Commission reported “unwanted pregnancies, including the cases of two 14 and 16 year old girls who had been raped after which they found themselves doubly burdened.”<sup>45</sup>
  - As the Women’s Commission for Refugee Women and Children documented following the post-election violence,

*Cases of women and girls suffering from unsafe abortion had been reported in camps [for internally displaced persons]. Nakuru Showground clinic reported that in the week preceding the interview alone, there were two patients, one a 16-year-old who had used a pen and the other a 20-year-old who had used a coat hanger. The two women had come to the clinic for infection treatment.*<sup>46</sup>
- **Sexual violence and coercion in schools is a serious problem.** A recent study by the Centre for the Study of Adolescence found that at least one in twenty boys in high school reported coercing girls into sex; the same number of boys reported having made a girl pregnant.<sup>47</sup>
- **Many poor women and girls turn to “survival sex” out of economic desperation.** Due to the worsening economic situation and devastating economic impact of the post-election violence that left hundreds of thousands of Kenyans internally displaced,<sup>48</sup> poor women and girls sometimes engage in “survival sex”—trading sexual acts for basic life necessities. A 2003 study by the Center for the Study of Adolescence found that 56% of secondary school students “had exchanged sex for money.”<sup>49</sup>

## **CONCLUSION FIVE: EMERGENCY CONTRACEPTION (EC), EVEN FOR VICTIMS OF SEXUAL VIOLENCE, IS LARGELY UNAVAILABLE; ACCESS TO EC IS HINDERED BY DISCRIMINATION AND MISINFORMATION**

### **The context:**

- The Ministry of Health's Sexual Violence Guidelines state that "[i]n view of the psychological consequences of conceiving after being raped, every non-pregnant woman/girl of childbearing age not covered by a reliable form of contraception, should be offered emergency contraception."<sup>50</sup>
- The Ministry of Health's 2008 EC guidelines for healthcare providers state that "EC is used after unprotected sex" and does not limit the situations in which it can be dispensed.<sup>51</sup> They further state that "EC can be safely used by adolescents."<sup>52</sup>
- EC is also supposed to be available free at public health facilities.<sup>53</sup>

### **Research conclusions:**

- **Many women who have survived sexual violence never receive emergency contraception (EC).** The reasons for this vary. For some women, a lack of transportation prevents them from seeking medical attention; for others, the stigma associated with sexual violence and rape deters them from obtaining healthcare. Supplies of EC are also unavailable at hospitals and clinics that are Catholic facilities and those under the Christian Health Association of Kenya.<sup>54</sup>
- **The time period for intervention using EC is sometimes interpreted too narrowly by providers.** Kenya's Sexual Violence Guidelines state that EC can be given up to 72 hours after rape.<sup>55</sup> Yet this is inconsistent with the World Health Organization's recommendations<sup>56</sup> and the Ministry of Health's guidelines on EC, which state that EC should be used "as soon as possible, but within 120 hours of unprotected sex."<sup>57</sup> Many of the healthcare providers interviewed for this report asserted that EC had to be administered within 72 hours.<sup>58</sup>
- **Despite the clear public demand for EC, Kenyan public health facilities are insufficiently stocked and face persistent shortages in supply.** Maintaining consistent government stocks of emergency contraception has proven challenging in Kenya.<sup>59</sup> By the end of June 2009, only 0.3 months' worth of EC stock remained in government stores, whereas the minimum recommended stock is 10.3 months.<sup>60</sup>
- **Interviews suggest women are being denied EC by providers and pharmacists on the basis of age and marital status and personal perceptions of "abuse" of EC,** despite the fact that these are not valid reasons to withhold EC according to the Ministry of Health's 2008 EC guidelines for healthcare providers.<sup>61</sup>
- **Accounts of arbitrary refusals to provide EC were common from the women and providers interviewed for this report.** Young women and adolescents from Kibera who participated in a focus group discussion stated that "for EC they [government family planning facilities] normally prefer you to be 21 years or older."<sup>62</sup> This was corroborated by pharmacists. A programs pharmacist at a family planning center explained that the "reason why [pharmacists] would hold back contraceptives is because the person looks young."<sup>63</sup>

## CONCLUSION SIX: THE STIGMA OF ABORTION AND ITS CRIMINALIZED LEGAL STATUS IMPERILS WOMEN'S HEALTH

### The context:

- Kenya's Penal Code lays out the penalties for a woman who obtains<sup>64</sup> an “unlawful” abortion, anyone who acts with the intent to “unlawfully” provide an abortion for a woman, and any person who supplies drugs or instruments to be used in the performance of an “unlawful” abortion.<sup>66</sup>
- The Penal Code can be read as creating a lawful exception to illegal abortion: when “a surgical operation...upon an unborn child” is performed “in good faith and with reasonable care” for the “preservation of the mother's life.”<sup>67</sup> However, the provision offers no guidance as to what circumstances may constitute the preservation of the woman's life—and there is no post-independence Kenyan High Court case law that authoritatively interprets this provision and makes clear the content of this exception.
- There is no administrative or judicial procedure in place in Kenya to challenge—in a timely and effective manner—a health care provider's decision to decline a woman's request for a lawful abortion.<sup>68</sup>

### Research conclusions:

- **Women resort to painful and dangerous methods to terminate unwanted pregnancy.** These methods include catheters,<sup>69</sup> crochet or knitting needles,<sup>70</sup> sticks,<sup>71</sup> pipes,<sup>72</sup> coils or wires,<sup>74</sup> and pens.<sup>74</sup> Other methods include ingesting dangerous substances or overdosing on medication, such as Jik (bleach) or a bluing agent (similar to bleach),<sup>75</sup> concentrated tea,<sup>76</sup> soapy water or detergent,<sup>77</sup> malaria pills,<sup>78</sup> and herbs acquired from an herbalist.<sup>79</sup> Lastly, some methods involve deliberate bodily injury, such as falling down.<sup>80</sup>
- **Women suffer from life-long complications and disabilities and death as a result of turning to unsafe abortion, including unsafe abortions performed by quacks.** One obstetrician-gynecologist consultant at New Nyanza Provincial Hospital in Kisumu told the Center: “Recently, we had a student in Form 4 [secondary school] who went for a quack abortion, got infected, and went into septic shock. The infection spread to her brain and now she is a vegetable. Eight weeks later and she is still there at the Provincial Hospital, right now, and she can't talk.”<sup>81</sup>
- **Women seeking abortion services sometimes experience degrading treatment by providers, including verbal abuse and the denial of pain medication or anesthesia.** A rape trauma counselor interviewed for this report told of a client who had sought an abortion after being brutally raped and becoming pregnant. The young woman went to a private facility in downtown Nairobi, recommended by her sister. Throughout the procedure, for which she was given no anesthesia, she was verbally abused by the two male providers who attended her. They said, “You will never do this again, come out and see what you have done so you don't go opening up your legs again to other men.”<sup>82</sup> According to her lawyer, they “brought the fetus in a bucket and put it in her face and said you need to stop spreading your legs for everyone.”<sup>83</sup> The woman suffered post-abortion complications from the procedure but refused to seek further care.<sup>84</sup>
- **There are few avenues for redress for women who experience abuses during the provision of abortion-related healthcare services.** One such example is a woman whose uterus was removed, without her consent, during an abortion procedure. In an interview for this report, an official with close ties to the Medical Board explained that the woman brought a complaint

before the Board; the provider, upon being questioned by the Board about the case, said that whatever wrong he committed, the woman also had done something unlawful and therefore she should be prosecuted as well. The woman dropped the case.<sup>85</sup>

- **Women in Kenya are regularly arrested for unlawfully procuring an abortion.** A community organizer from Kibera noted that “many women have been arrested” on abortion charges.<sup>86</sup> A reproductive rights researcher who is currently collecting abortion decisions from magistrate’s courts across the country stated that in the lower courts in Nyeri and Kisumu, there are approximately three cases being tried per week in which women are charged with procuring an illegal abortion.<sup>87</sup>
  - Of these cases not one of the women or girls tried had legal representation at trial.<sup>88</sup> Ten out of twenty cases examined involved schoolgirls, some of whom were minors.<sup>89</sup> In all the cases, the women pled guilty to the charges; as the researcher noted, “evidence doesn’t even have to be called.”<sup>90</sup>
  - A long-time Kibera resident and the mother of a young girl who died from an unsafe abortion said that, in Kibera, “[e]veryone is afraid. People in Kibera get arrested. If they find a fetus somewhere they will search all the women in the area to see who is bleeding and they will turn the woman over to the chief and over to the police.”<sup>91</sup>

## **CONCLUSION SEVEN: THE HIGH AND VARIABLE COST OF MEDICAL SERVICES IMPEDES ACCESS TO SAFE ABORTION, EVEN WHEN AVAILABLE UNDER LAW, DISPROPORTIONATELY AFFECTING YOUNG AND POOR WOMEN**

### **The context:**

- While Kenyan women with financial means usually have access to relatively safe abortions performed by private practitioners, most poor women must resort to unsafe and clandestine means.<sup>92</sup> Women qualifying for a legal abortion are rarely able to access a safe abortion in Kenya’s public healthcare system.
- Poverty affects women disproportionately: female-headed households in Kenya experience higher incidences of poverty than their male counterparts, in both rural and urban areas.<sup>93</sup> In a country where almost 40% of the population lives on less than two dollars a day and 52% of the population lives below the national poverty line, safe abortion services are out of reach for many.<sup>94</sup>

### **Research conclusions:**

- **The cost of safe abortion services varies widely.** It ranges from 500 shillings (\$6.50) to 9,000 shillings (\$118.00) from various providers. In contrast, herbalists and unqualified individuals may charge between 300–500 shillings (\$4–6.50) for their services.<sup>95</sup> A private provider in an informal settlement in Kisumu stated that:

*Women know about private providers but still go to quacks because they are cheaper. Quacks induce and then [the women] go to a government hospital to complete. This is cheaper than going straight to providers but the risk is complications.<sup>96</sup>*

- **The high cost of safe abortion services is sometimes driven by the perceived blanket illegality of the procedure.** As one clinical officer explained, “Because it’s illegal, there are people that are overcharging the patients and extorting money from patients.”<sup>97</sup>

## CONCLUSION EIGHT: DESPITE ITS CLEAR LEGALITY AND NECESSITY, SERIOUS BARRIERS IMPEDE ACCESS TO LIFE-SAVING POST-ABORTION CARE

### The context:

- The Ministry of Health has made clear that “emergency care for complications of abortion (post-abortion care), both spontaneous and induced, is legal and not punishable by any part of Kenya laws.”<sup>98</sup> According to its National Post Abortion Care Curriculum, comprehensive post-abortion care is “a life saving procedure that should be available to all women.”<sup>99</sup> However, the curriculum does not address whether a woman seeking post-abortion care is protected from punishment or arrest.
- The provision of post-abortion care is regulated by a number of policy documents issued by the Ministry of Health. These strategic plans, standards, and guidelines address service provision, the training of reproductive health service providers, and the minimum standards of care required for effective post-abortion care. Notably, there are no guidelines on fee structures for post-abortion care or fee exemptions or waivers for these services.
- There is a section containing technical guidelines on the management of complications of abortion within the Ministry of Health’s Essential Obstetric Care Manual;<sup>100</sup> however, it is unclear the extent to which providers are aware of these guidelines. The Ministry has not published any technical guidelines focused exclusively on the provision of post-abortion care.
- Although community education and awareness-raising about existing post-abortion care services was a key component of the Ministry of Health’s 2002 official standards for management of complications of unsafe abortion,<sup>101</sup> women remain unaware that post-abortion care is a legal service that should be available at government facilities.

### Research conclusions:

- **Women requiring post-abortion care must overcome a series of obstacles to access care at a healthcare facility and to obtain quality care from the healthcare providers on duty.** Barriers to access include the fear of prosecution and social stigma and the prohibitive costs associated with obtaining post-abortion care.
- **Fear of arrest upon seeking post-abortion care services is not unfounded.** A nurse who runs a maternity hospital in Nairobi and who provides post-abortion care stated that “there is a lot of threatening and mistreatment by the police. The police went to a clinic in Eastlands, found women in the waiting room [who were thought to be seeking abortion-related services] and they were all picked up.”<sup>102</sup>
- **Women delay seeking care because they fear social stigma.** A nurse who works both at a government facility and operates a private practice in Suba District, explained that the law deters and delays women’s access to post-abortion care: “Women may not seek post-abortion care because of the restriction from the government. They are afraid of the law. Women delay coming for treatment and then only come when they are worse.”<sup>103</sup> These delays can create additional barriers to care, as lower cadres of providers are often not equipped to handle serious complications and may need to refer women to a different facility, resulting in greater costs for care and transport.
- **In some cases, the fear of stigma is lethal.** In a focus group discussion in Mombasa conducted by the Center for Reproductive Rights, young women told of others they knew who had died from unsafe abortion: “One went to a quack at four months and bled to death. She didn’t have the cash to pay for treatment and was ashamed so didn’t want to go for



treatment—she was a Muslim student and didn't go because of shame,"<sup>104</sup> recounted one participant. Another woman told of a relative who "tried to abort, took a concoction . . . started bleeding, locked herself in her room and when we opened the door she had already died."<sup>105</sup>

- **Even when women do decide to obtain emergency care, their fear of the law presents additional barriers to immediate and effective care.** For example, women may not be forthcoming about their medical history. According to a long-practicing nurse-midwife, "that is the biggest challenge as providers. You get the wrong history. They lie about the month of pregnancy. They say they are three months pregnant when they are really six months pregnant,"<sup>106</sup> making appropriate care more difficult to determine and risking the health complications of improper post-abortion care treatment.
- **The cost of post-abortion care is a barrier.** According to an obstetrician-gynecologist at the University of Nairobi, the "use of public services has gone down because of fees. This prevents women from seeking post-abortion care. . . . The fee is a major barrier to access. Women might not come for services because they can't afford it."<sup>107</sup>
- **The women interviewed for the report appeared unaware that a fee-waiver system exists in most public health facilities for those who are unable to afford the cost of services such as post-abortion care.** The medical superintendent of Kisumu East District Hospital reinforced this proposition, asserting that "ignorance . . . that the fee can be waived" prevents women from seeking post-abortion care.<sup>108</sup> Nearly all of the public health providers interviewed, in contrast, mentioned the possibility of a fee waiver.<sup>109</sup>
- **Extended care in serious cases can be very expensive.** According to a doctor at Kenyatta National Hospital, one woman from an informal settlement in Nairobi who sought care after an unsafe abortion required two major abdominal surgeries, a stint in the intensive-care unit, and more than eight months' recovery in the hospital ward. Upon eventual discharge from the hospital, her total bill was 250,000 shillings (\$3,289).<sup>110</sup>
- **Women interviewed for this report also consistently raised bribery as an obstacle to—and requirement for—obtaining care.** In a focus group discussion with young women in Kibera, the participants agreed when one woman said, "The public hospitals will definitely ask for bribes [when providing post-abortion care]. They will threaten to turn you into the police unless you pay them."<sup>111</sup> At another focus group discussion with 19 young women in Mombasa, the consensus was that

*people charge money on top because it's illegal. If you want them to take care of you immediately, you need to pay a bribe in a government hospital, otherwise they'll take you to the ward and leave you there all day. You bribe them so they don't call the police too.*<sup>112</sup>

Bribes for post-abortion care services were perceived as common, revealed focus group discussions conducted by the Center for Reproductive Rights with women in Mombasa,<sup>113</sup> Kibera,<sup>114</sup> and Mbita<sup>115</sup> in Nyanza Province. The precise amount paid in bribes was unknown—"it's secret," agreed the women from Mbita.<sup>116</sup>

- **Patients are sometimes detained in healthcare facilities when they are unable to pay their medical bills for post-abortion care.** The hospital administration detains patients who cannot afford their fees upon discharge, holding them against their will until they find the requisite funds or until it is clear they cannot pay. In addition to holding them accountable for their

original hospital fees, explains a newspaper article, “hospitals continue to charge detained patients an average of \$5 to \$7 a day, so their debt continues to grow like a high-interest credit card balance.”<sup>117</sup>

- **Detention due to medical debt can further discourage women from seeking post-abortion care and has serious consequences for women and their families.** Prolonged detention, aside from constituting a serious human rights violation, may have additional ramifications for women’s livelihoods and the welfare of family members dependent on them for survival—often the very reasons a woman may have risked her life to procure an unsafe abortion in the first place.

## **CONCLUSION NINE: POST-ABORTION CARE, EVEN WHEN AVAILABLE, IS OFTEN DELAYED, LACKING IN QUALITY, AND CHARACTERIZED BY MISTREATMENT**

### **The context:**

- In the year prior to the 2004 Kenyan Service Provision Assessment Survey, only 5% of all service providers interviewed reported receiving in-service training on post-abortion care.<sup>118</sup> As a comparison, 25% of service providers reported receiving in-service training on preventing mother-to-child transmission of HIV<sup>119</sup> and 58% participated in a training course related to HIV/AIDS<sup>120</sup> in the 12 months preceding the survey.
- In 2006, the Ministry of Health drafted a National Reproductive Health Curriculum for Service Providers to address and standardize the various curricula used in training.<sup>121</sup> The curriculum contains a unit on post-abortion care and is meant to apply to all reproductive health service providers in Kenya, explicitly including clinical officers and nurses.<sup>122</sup> However, implementation of the policy has been poor leading not only to continuing confusion over nurses’ scope of practice,<sup>123</sup> but also to a failure to update existing curricula to comply with its requirements.<sup>124</sup>
- The Kenyan government’s National Post Abortion Care Curriculum, in discussing maternal mortality, states, “These women leave behind millions of motherless children whose survival is precarious due to lack of maternal support and care. Children who are left motherless due to maternal mortality are up to ten times more likely to die within two years than children with two living parents.”<sup>125</sup>

### **Research conclusions:**

- **A woman able to overcome the significant financial and social obstacles to seeking post-abortion care can encounter a new set of barriers to obtaining quality post-abortion care at the healthcare facility.** Delays in treatment, both deliberate and resource-based, are common. Care may be denied entirely for failure to pay a demanded bribe. When women do finally receive care, the quality of the care is often poor, characterized by verbal abuse from healthcare staff, poorly performed procedures by untrained providers lacking proficiency, and the absence of pain management.
- **Inconsistent availability of blood in Kenya’s blood banks may delay care and increase hospital fees for post-abortion care patients.** A professor of OB/GYN at the University of Nairobi/Kenyatta National Hospital, explained that one reason fees can be prohibitively high for some women seeking post-abortion care is because “blood is not easy to get so [women] have to wait a few days,”<sup>127</sup> thereby delaying their care and increasing their hospital bill.
- **Lack of equipment, lack of infection control, and incorrect use of equipment** leading to equipment breakdowns all contribute to the lack of availability and low quality of post-abortion care.

- o According to the 2004 KSPAS, among all facilities that offer delivery services in Kenya, only 16% have a vacuum aspirator and only 14% have a D&C kit.<sup>128</sup>
- o The capacity for infection control is limited in Kenyan healthcare facilities: 54% of government facilities, 52% of private-sector facilities, 84% of NGO-run facilities, and 73% faith-based facilities lack the capacity for full infection control, leaving the overall capacity for infection control in Kenya's healthcare system at 40%.<sup>129</sup>
- o Health facilities often face dual problems of a limited ability to sterilize equipment and control infection coupled with an insufficient supply of manual vacuum aspiration kits, creating a high risk of infection and delaying the provision of care. A nurse in a private clinic in Nairobi explained, "one kit is for ten patients so there are risks of infections."<sup>130</sup>
- o In addition, both public and private providers interviewed for this report attributed the insufficient number of MVA kits to the fact that kits were repeatedly breaking down.<sup>131</sup> Experts and practitioners linked the breakdown in kits to a lack of sufficient training.<sup>132</sup> One reproductive health specialist said that he has seen providers perform MVA procedures without knowing how to use the kit; he observed one provider trying to do an MVA who "broke three kits in one go."<sup>133</sup> Not only does this lack of training have a considerable impact on the availability of supplies—but to endure repeated attempts to perform an MVA procedure makes worse an already traumatic situation for women. As the reproductive health specialist stated, "One wonders what the quality of care would be in such situations . . ."<sup>134</sup>

- **Providers' negative attitudes about post-abortion care were consistently identified by women and providers as a widespread problem in public health facilities, manifesting itself in mistreatment from the withholding of care to verbal abuse.**

- o A clinical officer at a public district hospital typically sees his post-abortion care patients after they have seen a nurse. In his experience, "nurses are so abusive in their language. They say, 'You had sex, you had your excitement. Now you're crying, who will help you? We will just leave you to die.'"<sup>135</sup> As a result, he noted, most of the patients who experience such verbal abuse do not come back for follow-up care.<sup>136</sup>
- o Such abuse occurs regardless of whether post-abortion care patients have had a spontaneous or induced abortion. A nurse manager of a different district hospital observed that:

*[Women] who may need services may prefer not to come to the hospital. The attitude of the staff is wanting. They treat any patient, even if miscarriage naturally occurred, as criminal. Patients are reluctant to come because they don't want to be abused. The reception of patients is wanting. Attitudes need to change. Any abortion [spontaneous or induced] is treated as criminal until proven otherwise.<sup>137</sup>*

- **In addition to facing verbal abuse, failing to provide women with anesthesia or pain medication while undergoing post-abortion care is not uncommon in Kenya.** A 2004 study conducted by Ipas and the Ministry of Health on unsafe abortion in Kenya found that "[i]n general, women who presented at the hospitals with incomplete abortion, reported that the most traumatizing aspect of their abortion experience was the bleeding and the 'excruciating pain.' Women likely to have had induced abortion reported that they had undergone additional trauma from the surgical procedure, performed without the benefit of pain control."<sup>138</sup>

A reproductive healthcare specialist and trainer in manual vacuum aspiration (MVA) decried the practice of denying pain relief:

*Patients have rights and according to me if you're going to do MVA without pain care it is an assault on the person. You're not treating them, it's like assaulting them physically which is very wrong and unethical. We make them know [trainees] that this is a painful procedure and we have a means of controlling that pain and it should be given. . . . So if you have a health facility where they don't have pain killers—there should be analgesics and local anesthetics in place.<sup>139</sup>*

- **Post-abortion family planning counseling is inadequate.** Although “studies in Latin America and Africa have shown that after having an abortion patients will accept contraception at high rates [and that c]ontraceptive counseling and provision at the time of treatment reduced unintended pregnancies and repeat abortions by 50% over 1 year in Zimbabwe, compared with post-abortion patients who did not receive such services,”<sup>140</sup> family planning follow-up is only haphazardly available as part of post-abortion care.

A clinical officer at Kisumu East District Hospital explained that “family planning counseling after abortion depends on who sees you. Family planning is another section of the hospital. After I do [the procedure], they just go home. No family planning counseling.”<sup>141</sup> The impact of this approach can be seen in the official post-abortion care statistics collected at the same hospital: less than 33% of women who received post-abortion care services between January and June 2009 left with a family planning method.<sup>142</sup> In June 2009 alone, according to the register, not one of the 17 post-abortion care patients who were treated in the facility took up a family planning method upon discharge.<sup>143</sup>

## **CONCLUSION TEN: KEY MEDICAL PROVIDERS OF REPRODUCTIVE HEALTHCARE LACK TRAINING, EQUIPMENT, AND CLARITY ON THE LAW AND THEIR SCOPE OF PRACTICE**

### **The context:**

- The Kenyan healthcare system is not equipped to deal with the high rates of unsafe abortion cases presenting at its healthcare facilities. According to the 2004 KSPAS, only 9% of hospitals, maternities, and health centers have the capacity to provide basic emergency obstetric care.<sup>144</sup> Only 6% of hospitals, maternities, and health centers in Kenya were found to offer comprehensive emergency obstetric services.<sup>145</sup>
- Although the Ministry of Health has made clear that all hospitals, maternities, and health centers are expected to be able to offer 24-hour services, the 2004 KSPAS found that only 57% of hospitals, 59% of maternities, and 20% of health centers have the basic components to support such services.<sup>146</sup> Only 11% of all government-managed facilities have the basic components to support 24-hour emergency services.<sup>147</sup>
- Kenyan healthcare facilities often lack basic equipment necessary for the provision of post-abortion care and safe abortion, including latex gloves, soap, water, disinfecting solution, sterilization equipment, and the equipment used for post-abortion care.<sup>148</sup>

### **Research conclusions:**

- **Nurses lack both legal protection for performing abortions and clarity on the law.** According to most of the nurses interviewed for this report, the abortion law is not covered in their training. The mistaken belief among a number of those interviewed is that abortion is illegal, with no exception to preserve the woman's life or health.<sup>149</sup> The Nursing Council's Code of

Ethics and Professional Conduct for Nurses, under a non-exhaustive catalog of disciplinary offenses, lists “performing or assisting in illegal procedures e.g. procuring abortions” as a malpractice offense.<sup>150</sup> The code mentions no exceptions in which procuring an abortion may be considered legal.<sup>151</sup>

- **Clinical officers lack training and information on abortion law and practice.** Clinical officers are mid-level healthcare providers “who offer a wide range of medical services” and “supplement the work of medical doctors at all levels of healthcare.”<sup>152</sup> According to the Clinical Officers Council, which is charged with overseeing clinical officers’ training,<sup>153</sup> clinical officers are taught the content of the abortion law.<sup>154</sup> However, as with nurses, the educational focus appears to be primarily on the prohibitive nature of the Penal Code provisions. Clinical officers therefore believe the law only applies to the most extreme and indisputable—and therefore rarest—of circumstances. For example, explained a post-abortion care trainer for clinical officers and nurses, “people understand ‘save the woman’s life’ to be if the woman will die in the next five minutes.”<sup>155</sup>
- **Doctors, including gynecologists, also remain unclear about legal standards for abortion access.** “We didn’t talk about the law in university. At university we were taught about post-abortion care but not about termination,” a general practitioner trained at Moi University stated.<sup>156</sup> Similarly, a gynecologist trained at the University of Nairobi explained that they were never taught the law in medical school.<sup>157</sup> This fact may explain the incorrect belief of pediatrician and chief administrator at New Nyanza Provincial Hospital, as told to the Center for Reproductive Rights, that “there is no legal termination.”<sup>158</sup>
- **Lack of familiarity with the law and policies surrounding abortion can result in healthcare providers themselves creating barriers to women’s access to safe abortion.** Many providers believe that abortion is simply illegal and thus refrain from both offering services and referring women to other providers. Other healthcare providers erroneously believe that the law requires the written approval of gynecologists and psychiatrists—both a rarity in Kenya—to perform a termination, creating additional barriers to access and resulting in few women being able to benefit from a safe and legal abortion in public hospitals. A study carried out in Nairobi by a gynecologist found that all the recorded therapeutic abortion cases he identified had been performed only after obtaining a written recommendation from a psychiatrist.<sup>159</sup>
  - **The Medical Board’s Code of Conduct however does not contain a gynecologist or psychiatrist consultation requirement.** This misinformation can be traced to training schools’ curriculums: one of Kenya’s two medical schools teaches students to seek the written opinion of two medical practitioners, “usually a psychiatrist and another doctor”<sup>160</sup> while the nursing school at the University of Nairobi teaches nurses to first find a gynecologist and psychiatrist if a termination is to be considered.<sup>161</sup>
  - **The absence of policies or protocols specifically addressing abortion, or abortion-related referrals, means that providers have wide latitude to exercise their discretion in service provision.** Delaying tactics – or outright denial of services – are not uncommon.<sup>162</sup> A former nurse-manager of the OB/GYN department at Kenyatta National Hospital (KNH) recounted an incident at the hospital:

*We had a mentally [disabled] girl who was sick and pregnant. The decision was unanimous that the pregnancy was to be terminated but the doctor that was there that was most senior was anti-choice and said she couldn’t do it. [The girl] was almost at full term when we realized that the woman was physically unable to deliver [due to] high blood pressure and pelvic problems and we had to do a*

*hysterotomy [incision of the uterus]. The policies are on paper, but people are the policy. . . . The doctors in charge are supposed to be translating the guidelines and putting them into action but some doctors never do it.*<sup>163</sup>

- **The limited number of healthcare providers trained to perform abortions also dramatically restricts women’s access to safe abortion services—and magnifies concerns about provider barriers to access, given that few providers are able to offer services.** The lack of provider training is due primarily to poor government policies that have failed to clarify who may offer safe abortion services and under what circumstances, and to ensure that enough providers are sufficiently trained in the procedure.
- **The limited number of healthcare providers trained in post-abortion care was identified by many of those interviewed for this report as a distinct barrier to women’s access to care.** Immediate and efficient access to post-abortion care is particularly important because it is an emergency service; as stated in the government’s Post-Abortion Care Trainer’s Manual, post-abortion care is “often essential to save a woman’s life and preserve health.”<sup>164</sup> A clinical officer who practices at a district hospital discussed the delays in care caused by a lack of trained staff:

*We have insufficient staff and equipment for abortion. We don’t want to raise the issue because it would be controversial. . . . We have only ten trained clinical officers and five trained doctors in MVA. There are times when a woman comes in and no one is there who is trained in PAC [post-abortion care].*<sup>165</sup>

## **CONCLUSION ELEVEN: CRIMINALIZATION OF ABORTION STIGMATIZES AND HARMS MEDICAL PROVIDERS WHO PROVIDE ABORTION-RELATED CARE**

### **The context:**

- According to the chairman of the Medical Practitioners and Dentists Board [the Board], the statutory body charged with regulating medical and dental practice in Kenya, the Board has inspected and closed many clinics due to reports from members of the public and police of illegal abortions being performed there—in fact, “abortion is the commonest reason to close clinics,” said Dr. Kyambi.<sup>166</sup> He explained that the Medical Board has not been able to get “people in the act, but when the public complains we look for another reason to close the clinic.”<sup>167</sup> The Medical Board’s chief executive officer, explained the process similarly: “[The police and members of the public] report that this is a clinic carrying out abortions, then we get other reasons for closing it.”<sup>168</sup>
- Research has revealed that a woman’s community or family—more than anyone else—is generally responsible for reporting her and the provider to the police for suspected procurement of an illegal abortion.<sup>169</sup>

### **Research conclusions:**

- **Healthcare providers who offer post-abortion care or abortion services are significantly affected by Kenya’s restrictive abortion law in both their professional work and their personal lives.** Providers and their families encounter police and community harassment, are forced to pay bribes to police, are criminally prosecuted, face employment discrimination due to the stigma surrounding abortion, and struggle with the internal personal and professional tension that the law creates, pitting their duty to save lives and promote health against their obligation to obey the law.

- **Healthcare providers have been repeatedly deterred from offering post-abortion care services for fear of community and police harassment.** The instruments and supplies for the provision of post-abortion care are often identical to those used in procuring abortions and, as a result, many providers have been accused of performing illegal abortions. Unwilling to face potential criminal charges for being complicit in providing illegal abortions simply because they were offering post-abortion care services to survivors of unsafe abortion, many providers choose not to offer post-abortion care at all.<sup>170</sup>
  - o Many providers interviewed for this report recounted personal experiences with police harassment. Such harassment occurs primarily in private clinics or private hospitals and affects nurses, clinical officers, and doctors alike. Harassment may take the form of random police intrusions into health facilities or of targeted interventions resulting from community “tip-offs” or police initiatives—the latter often an effort to carry out personal retaliation or extort money from fearful healthcare providers.
- **Con artists also prey on providers. Members of the public are using providers’ vulnerability to public scorn as an easy way to make money.** Posing as policemen and journalists, these individuals storm a clinic with video cameras while the provider is in the midst of a procedure, and then demand money in exchange for not going public with the footage and arresting the provider. A Nairobi-based doctor was the victim of this scheme in late 2009, when individuals claiming to be police officers from the Central Police Station and journalists from a television station barged into his clinic while he was performing a manual vacuum aspiration (MVA) procedure on a woman. He was forced to pay a 200,000-shilling (\$2,632) bribe to these “policeman” and accompanying “journalists,” whose credentials were vague.<sup>171</sup>

## Conclusion

### Immediate Steps are Needed to Improve Reproductive Health for Women, Girls, and Families in Kenya

As this report demonstrates, when access to safe and legal abortion is limited, women resort to unsafe abortion, with devastating consequences for their health, lives, and families. This report documents these consequences in Kenya, highlighting how Kenya’s restrictive legal and policy regime, coupled with the Kenyan government’s failure to effectively address the root causes leading to unwanted pregnancies, leaves women squarely in harm’s way.

The report offers a comprehensive look at the corrosive effects of criminalizing abortion. It further demonstrates the toll the law has on the lives of healthcare providers and on their ability to effectively and ethically comply with the dictates of their profession: to save the lives and protect the health of their patients. Finally, the overwhelming resource burden placed on the healthcare system by the number of patients seeking post-abortion care can be traced directly to Kenya’s restrictive abortion law.

Reform is needed to address the problem of unsafe abortion and low-quality abortion care. The following section provides recommendations for concrete steps that would dramatically improve—and save—the lives of women and girls in Kenya.